IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 11/15/2010 16:23
FORM APPROVED
OMB NO. 0938-0050

THIS REPORT IS REQUIRED BY LAW (42 USC 1395g; 42 CFR 413.20(b)). FAILURE TO REPORT CAN RESULT IN ALL INTERIM PAYMENTS MADE SINCE THE BEGINNING OF THE COST REPORT PERIOD BEING DEEMED OVERPAYMENTS (42 USC 1395g).

WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1311	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/15/2010 TIME 16:23

PART I - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED BY THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISIONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FAIRFIELD MEMORIAL HOSPITAL 14-1311
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

ECR ENCRYPTION INFORMATION
DATE: 11/15/2010 TIME 16:23

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PI ENCRYPTION INFORMATION
DATE: 11/15/2010 TIME 16:23

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OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX	
		1	A 2	B 3	4	
1	HOSPITAL	0	117,910	208,614		0
5	HOSPITAL-BASED SNF	0	0	0		0
6	HOSPITAL-BASED NF	0	0	0		0
7	HOSPITAL-BASED HHA	0	0	0		0
9	RHC	0	0	-110,295		0
100	TOTAL	0	117,910	98,319		0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

IN LIEU OF FORM CMS-2552-96(04/2005)
PREPARED 11/15/2010 15:45
FORM APPROVED
OMB NO. 0938-0050

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WORKSHEET S
PARTS I & II

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	PROVIDER NO: 14-1311	PERIOD FROM 7/ 1/2009 TO 6/30/2010	INTERMEDIARY USE ONLY --AUDITED --DESK REVIEW --INITIAL --REOPENED --FINAL 1-MCR CODE 00 - # OF REOPENINGS	DATE RECEIVED: / / INTERMEDIARY NO:

ELECTRONICALLY FILED COST REPORT DATE: 11/15/2010 TIME 15:45

PART I - CERTIFICATION

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY:
FAIRFIELD MEMORIAL HOSPITAL 14-1311
FOR THE COST REPORTING PERIOD BEGINNING 7/ 1/2009 AND ENDING 6/30/2010 AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT, AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

OFFICER OR ADMINISTRATOR OF PROVIDER(S)

TITLE

DATE

PART II - SETTLEMENT SUMMARY

		TITLE V	TITLE XVIII		TITLE XIX
			A	B	
		1	2	3	4
1	HOSPITAL	0	117,910	208,614	0
5	HOSPITAL-BASED SNF	0	0	0	0
6	HOSPITAL-BASED NF	0	0	0	0
7	HOSPITAL-BASED HHA	0	0	0	0
9	RHC	0	0	-110,295	0
100	TOTAL	0	117,910	98,319	0

THE ABOVE AMOUNTS REPRESENT "DUE TO" OR "DUE FROM" THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS
1 STREET: 303 NW 11TH ST P.O. BOX:
CITY: FAIRFIELD STATE: IL ZIP CODE: 62837- COUNTY: WAYNE

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION;

	COMPONENT	COMPONENT NAME	PROVIDER NO.	NPI NUMBER	DATE CERTIFIED	PAYMENT SYSTEM (P,T,O OR N) V	XVIII	XIX
	0	1	2	2.01	3	4	5	6
02.00	HOSPITAL	FAIRFIELD MEMORIAL HOSPITAL	14-1311		4/ 1/2001	N	O	O
06.00	HOSPITAL-BASED SNF	FAIRFIELD MEMORIAL HOSPITAL	14-5552		3/26/1985	N	P	N
07.00	HOSPITAL-BASED NF	FAIRFIELD MEMORIAL HOSPITAL WAYFAIR	14-0000		7/ 1/1966	N		O
09.00	HOSPITAL-BASED HHA	FAIRFIELD MEMORIAL HOSPITAL	14-7612		5/ 1/1995	N	P	N
14.00	HOSPITAL-BASED RHC	FAIRFIELD RHC	14-8500		3/13/2009	N	O	N

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 7/ 1/2009 TO: 6/30/2010

		1	2			
18	TYPE OF CONTROL	2				
	TYPE OF HOSPITAL/SUBPROVIDER					
19	HOSPITAL	1				
20	SUBPROVIDER					
	OTHER INFORMATION					
21	INDICATE IF YOUR HOSPITAL IS EITHER (1)URBAN OR (2)RURAL AT THE END OF THE COST REPORT PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.					
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE HOSPITAL ADJUSTMENT IN ACCORDANCE WITH 42 CFR 412.106? ENTER IN COLUMN 1 "Y" FOR YES OR "N" FOR NO. IS THIS FACILITY SUBJECT TO THE PROVISIONS OF 42 CFR 412.106(c)(2) (PICKLE AMENDENT HOSPITALS)? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO.	N				
21.02	HAS YOUR FACILITY RECEIVED A NEW GEOGRAPHIC RECLASSICATION STATUS CHANGE AFTER THE FIRST DAY OF THE COST REPORTING PERIOD FROM RURAL TO URBAN AND VICE VERSA? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, ENTER IN COLUMN 2 THE EFFECTIVE DATE (MM/DD/YYYY) (SEE INSTRUCTIONS).					
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1)URBAN OR (2)RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHICAL RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (MM/DD/YYYY)(SEE INSTRUCTIONS) DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 "Y" OR "N". ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.	2	N		Y	9914
21.04	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2				
21.05	FOR STANDARD GEOGRAPHIC CLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1)URBAN OR (2)RURAL	2				
21.06	DOES THIS HOSPITAL QUALIFY FOR THE 3-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR SMALL RURAL HOSPITAL; UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA §5105 OR MIPPA §147? (SEE INSTRUC) ENTER "Y" FOR YES, AND "N" FOR NO.	N				
21.07	DOES THIS HOSPITAL QUALIFY AS A SCH WITH 100 OR FEWER BEDS UNDER MIPPA §147? ENTER "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS). IS THIS A SCH OR EACH THAT QUALIFIES FOR THE OUTPATIENT HOLD HARMLESS PROVISION IN ACA SECTION 3121? ENTER IN COLUMN 2 "Y" FOR YES OR "N" FOR NO. (SEE INSTRUCTIONS)	N	N			
21.08	WHICH METHOD IS USED TO DETERMINE MEDICAID DAYS ON S-3, PART I, COL. 5 ENTER IN COLUMN 1, "1" IF IT IS BASED ON DATE OF ADMISSION, "2" IF IT IS BASED ON CENSUS DAYS, OR "3" IF IT IS BASED ON DATE OF DISCHARGE. IS THIS METHOD DIFFERENT THAN THE METHOD USED IN THE PRECEEDING COST REPORTING PERIOD? ENTER IN COLUMN 2, "Y" FOR YES OR "N" FOR NO.					
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?	N				
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW.	N				
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.		/ /		/ /	
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION DATE IN COL. 3.		/ /		/ /	
24	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 2 AND TERMINATION DATE IN COLUMN 3 (MM/DD/YYYY)				/ /	
24.01	IF THIS IS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COLUMN 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER 12/26/2007) IN COLUMN 3 (mm/dd/yyyy).				/ /	

25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE RECEIVING PAYMENTS FOR I&R?	N				
	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-I, CHAPTER 4?					
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.					
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-I, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.					
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N				
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME FTE CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)					
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENTS CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER "Y" FOR YES AND "N" FOR NO IN THE APPLICABLE COLUMNS (SEE INSTRUCTIONS)					
26	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH),ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE C/R PERIOD. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0				
26.01	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING:	/ /				
26.02	ENTER THE APPLICABLE SCH DATES: BEGINNING: / / ENDING:	/ /				
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS. IF YES, ENTER THE AGREEMENT DATE (MM/DD/YYYY) IN COLUMN 2.	N	/ /			
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WERE NO MEDICARE UTILIZATION ENTER "Y", IF "N" COMPLETE LINES 28.01 AND 28.02	N				
		1	2	3	4	
28.01	IF HOSPITAL BASED SNF, ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COLUMN 1. ENTER IN COLUMNS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER THE OCTOBER 1ST (SEE INSTRUCTIONS)	100	0.8386	0.8312		
28.02	ENTER IN COLUMN 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE(FROM YOUR FISCAL INTERMEDIARY) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PPS PAYMENT. IN COLUMN 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL (2). IN COLUMN 3 ENTER THE SNF MSA CODE OR TWO CHARACTER STATE CODE IF A RURAL BASED FACILITY. IN COLUMN 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY	256.96	2	14	99914	
	A NOTICE PUBLISHED IN THE "FEDERAL REGISTER" VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 "Y" FOR YES OR "N" FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTR)	%	Y/N			
28.03	STAFFING	1.00%	Y			
28.04	RECRUITMENT	0.00%				
28.05	RETENTION	0.00%				
28.06	TRAINING	0.00%				
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?	N				
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL(CAH)? (SEE 42 CFR 485.606ff)	Y				
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS AN RPCH/CAH? SEE 42 CFR 413.70	N				
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES? (SEE INSTRUCTIONS)	N				
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000).	N				
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIBIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER "Y" FOR YES AND "N" FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II	N				
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
31.01	IS THIS A RURAL SUBPROVIDER 1 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
31.02	IS THIS A RURAL SUBPROVIDER 2 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
31.03	IS THIS A RURAL SUBPROVIDER 3 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
31.04	IS THIS A RURAL SUBPROVIDER 4 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
31.05	IS THIS A RURAL SUBPROVIDER 5 QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).	N				
	MISCELLANEOUS COST REPORT INFORMATION					
32	IS THIS AN ALL-INCLUSIVE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) COL 2.	N				
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT? ENTER "Y" FOR YES AND "N" FOR NO IN COLUMN 2	N	N			
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40 (f)(1)(i) TEFRA?	N				
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N				
35.01	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N				
35.02	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N				
35.03	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N				
35.04	HAVE YOU ESTABLISHED A NEW SUBPROVIDER (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?	N				

		V	XVIII	XIX
	ECTIVE PAYMENT SYSTEM (PPS)-CAPITAL	1	2	3
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.320? (SEE INSTRUCTIONS)	N	N	N
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS? (SEE INSTRUCTIONS)	N	N	N
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF THE FED RATE?	N	N	N

TITLE XIX INPATIENT SERVICES

38	DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES?	Y
38.01	IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART?	N
38.02	DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY?	N
38.03	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)?	N
38.04	DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX?	N

40	ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB 15-I, CHAP 10? IF YES, AND THIS FACILITY IS PART OF A CHAIN ORGANIZATION, ENTER IN COLUMN 2 THE CHAIN HOME OFFICE CHAIN NUMBER. (SEE INSTRUCTIONS).	Y	
40.01	NAME: FI/CONTRACTOR NAME		FI/CONTRACTOR #
40.02	STREET: P.O. BOX:		
40.03	CITY: STATE: ZIP CODE:		
41	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y	
42	ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.01	ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
42.02	ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
43	ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS?	N	
44	IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPATIENT SERVICES ONLY?	N	
45	HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILED COST REPORT? SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE IN COLUMN 2.	N	00/00/0000
45.01	WAS THERE A CHANGE IN THE STATISTICAL BASIS?		
45.02	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION?		
45.03	WAS THE CHANGE TO THE SIMPLIFIED COST FINDING METHOD?		
46	IF YOU ARE PARTICIPATING IN THE NHCMQ DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE (SEE INSTRUCTIONS).		

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COSTS OR CHARGES, ENTER "Y" FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION. ENTER "N" IF NOT EXEMPT. (SEE 42 CFR 413.13.)

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC
	1	2	3	4	5
0	HOSPITAL N	N	N	N	N
49.00	SNF N	N			
50.00	HHA N	N			

52	DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)? (SEE INSTRUCTIONS)	N
52.01	IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTIONS PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE WORKSHEET L, PART IV	N
53	IF YOU ARE A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.	0
53.01	MDH PERIOD: BEGINNING: / / ENDING: / /	
54	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:	
	PREMIUMS: 0	
	PAID LOSSES: 0	
	AND/OR SELF INSURANCE: 0	
54.01	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N
55	DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER "Y" FOR YES AND "N" FOR NO.	N

		DATE	Y OR N	LIMIT	Y OR N	FEES
		0	1	2	3	4
56	ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COLUMN 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY AND THE APPLICABLE DATES FOR THOSE LIMITS IN COLUMN 0. IF THIS IS THE FIRST YEAR OF OPERATION NO ENTRY IS REQUIRED IN COLUMN 2. IF COLUMN 1 IS Y, ENTER Y OR N IN COLUMN 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COLUMN 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.		N	0.00		0
56.01	ENTER SUBSEQUENT AMBULANCE PAYMENT LIMIT AS REQUIRED. SUBSCRIPT IF MORE THAN 2 LIMITS APPLY. ENTER IN COLUMN 4 THE FEE SCHEDULES AMOUNTS FOR INITIAL OR SUBSEQUENT PERIOD AS APPLICABLE.			0.00		0
56.02	THIRD AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0
56.03	FOURTH AMBULANCE LIMIT AND FEE SCHEDULE IF NECESSARY.			0.00		0

57	ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?	N	
	ARE YOU AN INPATIENT REHABILITATION FACILITY(IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.	N	
58.01	IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER "Y" FOR YES OR "N" FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 "Y"FOR YES OR "N" FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTR).		0
59	ARE YOU A LONG TERM CARE HOSPITAL (LTCH)? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, HAVE YOU MADE THE ELECTION FOR 100% FEDERAL PPS REIMBURSEMENT? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 "Y" FOR YES AND "N" FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 "Y" FOR YES AND "N" FOR NO. (SEE INSTRUCTIONS)	N	
60.01	IF LINE 60 COLUMN 1 IS Y, AND THE FACILITY IS AN IPF SUBPROVIDER, WERE RESIDENTS TRAINING IN THIS FACILITY IN ITS MOST RECENT COST REPORTING PERIOD FILED BEFORE NOV. 15, 2004? ENTER "Y" FOR YES AND "N" FOR NO. IS THIS FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(C)? ENTER IN COL. 2 "Y" FOR YES OR "N" FOR NO. IF COL. 2 IS Y, ENTER 1, 2 OR 3 RESPECTIVELY IN COL. 3, (SEE INSTRUC). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COL. 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUC).		0

MULTICAMPUS

61.00 IS THIS FACILITY PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSA? ENTER "Y" FOR YES AND "N" FOR NO.

IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL.2, ZIP IN COL 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.

	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS
62.00						0.00

LEMENT DATA

63.00 WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER "Y" FOR YES AND "N" FOR NO IN COL. 1. IF COL. 1 IS "Y", ENTER THE "PAID THROUGH" DATE OF THE PS&R IN COL. 2 (MM/DD/YYYY). / /

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2009 TO 6/30/2010 PREPARED 11/15/2010 WORKSHEET S-3 PART I

	COMPONENT	NO. OF BEDS 1	BED DAYS AVAILABLE 2	CAH HOURS 2.01	I/P DAYS / O/P VISITS / TRIPS -- TITLE V 3	TITLE XVIII 4	NOT LTCH N/A 4.01	TOTAL TITLE XIX 5
1	ADULTS & PEDIATRICS	21	7,665	85,800.00		2,130		330
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS	21	7,665	85,800.00		2,130		330
6	INTENSIVE CARE UNIT	4	1,460	9,792.00		254		
11	NURSERY							
12	TOTAL	25	9,125	95,592.00		2,384		330
13	RPCH VISITS							
15	SKILLED NURSING FACILITY	30	10,950			2,241		
16	NURSING FACILITY	104	37,960					23,766
18	HOME HEALTH AGENCY					3,738		
24	RURAL HEALTH CLINIC					5,456		
25	TOTAL	159						
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I/P DAYS / TITLE XIX ADMITTED 5.01	OBSERVATION BEDS NOT ADMITTED 5.02	O/P VISITS TOTAL ALL PATS 6	TRIPS -- TOTAL OBSERVATION BEDS ADMITTED 6.01	NOT ADMITTED 6.02	INTERNS & RES. FTES -- TOTAL 7	LESS I&R REPL NON-PHYS ANES 8
1	ADULTS & PEDIATRICS			2,919				
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS			2,919				
6	INTENSIVE CARE UNIT			339				
11	NURSERY							
12	TOTAL			3,258				
13	RPCH VISITS							
15	SKILLED NURSING FACILITY			6,615				
16	NURSING FACILITY			25,894				
18	HOME HEALTH AGENCY			4,863				
24	RURAL HEALTH CLINIC			17,050				
25	TOTAL							
26	OBSERVATION BED DAYS			893		893		
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

	COMPONENT	I & R FTES NET 9	FULL TIME EQUIV -- EMPLOYEES ON PAYROLL 10	NONPAID WORKERS 11	DISCHARGES -- TITLE V 12	TITLE XVIII 13	TITLE XIX 14	TOTAL ALL PATIENTS 15
1	ADULTS & PEDIATRICS					654	115	991
2	HMO							
2 01	HMO - (IRF PPS SUBPROVIDER)							
3	ADULTS & PED-SB SNF							
4	ADULTS & PED-SB NF							
5	TOTAL ADULTS AND PEDS							
6	INTENSIVE CARE UNIT							
11	NURSERY							
12	TOTAL		162.20			654	115	991
13	RPCH VISITS							
15	SKILLED NURSING FACILITY		17.24					
16	NURSING FACILITY		71.92					
18	HOME HEALTH AGENCY		5.82					
24	RURAL HEALTH CLINIC		4.15					
25	TOTAL		261.33					
26	OBSERVATION BED DAYS							
27	AMBULANCE TRIPS							
28	EMPLOYEE DISCOUNT DAYS							
28 01	EMP DISCOUNT DAYS -IRF							
29	LABOR & DELIVERY DAYS							

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET S-4
HHA NO:	TO 6/30/2010	
14-7612		
COUNTY:	WAYNE	

HOME HEALTH AGENCY STATISTICAL DATA

HHA 1

		TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4
1	HOME HEALTH AIDE HOURS	0	0	0	0
2	UNDUPLICATED CENSUS COUNT		159.00		53.00

		TOTAL 5
1	HOME HEALTH AIDE HOURS	0
2	UNDUPLICATED CENSUS COUNT	212.00

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES
(FULL TIME EQUIVALENT)

ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK 40.00

HHA NO. OF FTE EMPLOYEES (2080 HRS)

		STAFF 1	CONTRACT 2	TOTAL 3
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)			
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)			
5	OTHER ADMINISTRATIVE PERSONEL			
6	DIRECTING NURSING SERVICE			
7	NURSING SUPERVISOR			
8	PHYSICAL THERAPY SERVICE			
9	PHYSICAL THERAPY SUPERVISOR			
10	OCCUPATIONAL THERAPY SERVICE			
11	OCCUPATIONAL THERAPY SUPERVISOR			
12	SPEECH PATHOLOGY SERVICE			
13	SPEECH PATHOLOGY SUPERVISOR			
14	MEDICAL SOCIAL SERVICE			
15	MEDICAL SOCIAL SERVICE SUPERVISOR			
16	HOME HEALTH AIDE			
17	HOME HEALTH AIDE SUPERVISOR			
18				

	HOME HEALTH AGENCY MSA CODES	1	1.01
19	HOW MANY MSAs IN COL. 1 OR CBSAs IN COL. 1.01 DID YOU PROVIDER SERVICES TO DURING THE C/R PERIOD?	1	0
20	LIST THOSE MSA CODE(S) IN COL. 1 & CBSA CODE(S) IN COL. 1.01 SERVICED DURING THIS C/R PERIOD (LINE 20 CONTAINS THE FIRST CODE).	9914	

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

		FULL EPISODES WITHOUT OUTLIERS 1	FULL EPISODES WITH OUTLIERS 2	LUPA EPISODES 3	PEP ONLY EPISODES 4
21	SKILLED NURSING VISITS	1,989	445	27	27
22	SKILLED NURSING VISIT CHARGES	218,790	48,950	2,970	2,970
23	PHYSICAL THERAPY VISITS	877	2	9	26
24	PHYSICAL THERAPY VISIT CHARGES	96,470	220	990	2,860
25	OCCUPATIONAL THERAPY VISITS	256	1	6	0
26	OCCUPATIONAL THERAPY VISIT CHARGES	28,160	110	660	0
27	SPEECH PATHOLOGY VISITS	71	0	0	0
28	SPEECH PATHOLOGY VISIT CHARGES	8,165	0	0	0
29	MEDICAL SOCIAL SERVICE VISITS	0	0	0	0
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0	0
31	HOME HEALTH AIDE VISITS	2	0	0	0
32	HOME HEALTH AIDE VISIT CHARGES	124	0	0	0
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	3,195	448	42	53
34	OTHER CHARGES	42,261	8,137	492	56
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	393,970	57,417	5,112	5,886
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	194	0	13	5
37	TOTAL NUMBER OF OUTLIER EPISODES	0	9	0	0
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	18,165	3,435	270	0

HOSPITAL-BASED HOME HEALTH AGENCY
STATISTICAL DATA

HOME HEALTH AGENCY STATISTICAL DATA

PROVIDER NO:	14-1311	PERIOD:	
HHA NO:	14-7612	FROM	7/ 1/2009
COUNTY:	WAYNE	TO	6/30/2010

PREPARED 11/15/2010
WORKSHEET S-4

HHA 1

PPS ACTIVITY DATA - APPLICABLE FOR SERVICES ON
OR AFTER OCTOBER 1, 2000

		SCIC WITHIN A PEP 5	SCIC ONLY EPISODES 6	TOTAL (COLS. 1-6) 7
21	SKILLED NURSING VISITS	0	0	2,488
22	SKILLED NURSING VISIT CHARGES	0	0	273,680
23	PHYSICAL THERAPY VISITS	0	0	914
24	PHYSICAL THERAPY VISIT CHARGES	0	0	100,540
25	OCCUPATIONAL THERAPY VISITS	0	0	263
26	OCCUPATIONAL THERAPY VISIT CHARGES	0	0	28,930
27	SPEECH PATHOLOGY VISITS	0	0	71
28	SPEECH PATHOLOGY VISIT CHARGES	0	0	8,165
29	MEDICAL SOCIAL SERVICE VISITS	0	0	0
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	0	0	0
31	HOME HEALTH AIDE VISITS	0	0	2
32	HOME HEALTH AIDE VISIT CHARGES	0	0	124
33	TOTAL VISITS (SUM OF LINES 21,23,25,27,29 & 31)	0	0	3,738
34	OTHER CHARGES	0	0	50,946
35	TOTAL CHARGES (SUM OF LNS 22,24,26,28,30,32 & 34)	0	0	462,385
36	TOTAL NUMBER OF EPISODES (STANDARD/NON OUTLIER)	0	0	212
37	TOTAL NUMBER OF OUTLIER EPISODES	0	0	9
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	0	0	21,870

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET S-7

	GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	SERVICES PRIOR TO 10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	SERVICES ON/AFTER 10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	SRVCS 4/1/01 TO 9/30/01 DAYS
	1	2	3	3.01	4	4.01	4.02	4.03
1		RUC						
2		RUB		82				
3		RUA		7				
3	.01	RUX						
3	.02	RUL		53				
4		RVC		14				
5		RVB		119				
6		RVA		227				
6	.01	RVX		74				
6	.02	RVL		170				
7		RHC		131				
8		RHB		261				
9		RHA		135				
9	.01	RHX						
9	.02	RHL						
10		RMC		7				
11		RMB		74				
12		RMA		39				
12	.01	RMX		284				
12	.02	RML		289				
13		RLB						
14		RLA						
14	.01	RLX						
15		SE3		54				
16		SE2		157				
17		SE1						
18		SSC		2				
19		SSB						
20		SSA		37				
21		CC2		2				
22		CC1		1				
23		CB2						
24		CB1						
25		CA2						
26		CA1		7				
27		IB2						
28		IB1						
29		IA2						
		IA1						
31		BB2						
32		BB1						
33		BA2						
34		BA1						
35		PE2						
36		PE1						
37		PD2						
38		PD1						
39		PC2						
40		PC1						
41		PB2						
42		PB1		1				
43		PA2						
44		PA1		14				
45		AAA						
45	.01	ES3						
45	.02	ES2						
45	.03	ES1						
45	.04	HE2						
45	.05	HE1						
45	.06	HD2						
45	.07	HD1						
45	.08	HC2						
45	.09	HC1						
45	.10	HB2						
45	.11	HB1						
45	.12	LE2						
45	.13	LE1						
45	.14	LD2						
45	.15	LD1						
45	.16	LC2						
45	.17	LC1						
45	.18	LB2						
45	.19	LB1						
45	.20	CE2						
45	.21	CE1						
45	.22	CD1						
45	.23	CD1						
5		TOTAL		2,241				

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET S-7

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO 10/1 RATE	SERVICES PRIOR TO 10/1 DAYS	SERVICES ON/AFTER 10/1 RATE	SERVICES ON/AFTER 10/1 DAYS	SRVCS 4/1/01 TO 9/30/01 RATE	SRVCS 4/1/01 TO 9/30/01 DAYS
1	2	3	3.01	4	4.01	4.02	4.03

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8386
Wage Index Factor (after 10/01) : 0.8312
SNF Facility Specific Rate : 256.96
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
1	2	4.05	4.06	5

1		RUC
2		RUB
3		RUA
3	.01	RUX
3	.02	RUL
4		RVC
5		RVB
6		RVA
6	.01	RVX
6	.02	RVL
7		RHC
8		RHB
9		RHA
9	.01	RHX
9	.02	RHL
10		RMC
11		RMB
12		RMA
12	.01	RMX
12	.02	RML
13		RLB
14		RLA
14	.01	RLX
[illegible]		SE3
		SE2
17		SE1
18		SSC
19		SSB
20		SSA
21		CC2
22		CC1
23		CB2
24		CB1
25		CA2
26		CA1
27		IB2
28		IB1
29		IA2
30		IA1
31		BB2
32		BB1
33		BA2
34		BA1
35		PE2
36		PE1
37		PD2
38		PD1
39		PC2
40		PC1
41		PB2
42		PB1
43		PA2
44		PA1
45		AAA
45	.01	ES3
45	.02	ES2
45	.03	ES1
45	.04	HE2
45	.05	HE1
45	.06	HD2
45	.07	HD1
45	.08	HC2
45	.09	HC1
	.10	HB2
[illegible]	.11	HB1
45	.12	LE2
45	.13	LE1
45	.14	LD2
45	.15	LD1
45	.16	LC2
45	.17	LC1
45	.18	LB2

	GROUP(1)	M3PI REVENUE CODE	HIGH COST(2) RUGs DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.05	4.06	5
45 .19	LB1				
45 .20	CE2				
45 .21	CE1				
45 .22	CD1				
45 .23	CD1				
46	TOTAL				

(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

(4) Additional Rugs were published in the "Federal Register", Vol. 74 No. 153 August 11,2009, page 40286. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

Worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01)	:	0.8386
Wage Index Factor (after 10/01)	:	0.8312
SNF Facility Specific Rate	:	256.96
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

	GROUP(1)	M3PI REVENUE CODE	SERVICES BASE RATE	PRIOR TO RATE	OCTOBER 1ST DAYS	SERVICES BASE RATE	ON OR AFTER RATE	OCTOBER 1ST DAYS
	1		3a	3	3.01	4a	4	4.01
1		RUC	497.80			495.77		
2		RUB	460.49			459.15	459.15	82
3		RUA	441.19			440.83	440.83	7
3	.01	RUX	577.55			570.35		
3	.02	RUL	513.24			510.17	510.17	53
4		RVC	393.12			388.01	388.01	14
5		RVB	375.12			371.01	371.01	119
6		RVA	340.39			339.61	339.61	227
6	.01	RVX	433.00			427.27	427.27	74
6	.02	RVL	405.99			401.10	401.10	170
7		RHC	336.86			330.81	330.81	131
8		RHB	322.72			317.73	317.73	261
9		RHA	300.84			298.10	298.10	135
9	.01	RHX	362.60			356.97		
9	.02	RHL	356.16			349.12		
10		RMC	307.99			302.74	302.74	7
11		RMB	300.27			294.89	294.89	74
12		RMA	293.84			289.66	289.66	39
12	.01	RMX	408.32			398.25	398.25	284
12	.02	RML	376.16			368.16	368.16	289
13		RLB	266.93			261.00		
14		RLA	229.62			225.67		
14	.01	RLX	288.79			281.93		
15		SE3	323.53			310.71	310.71	54
16		SE2	275.94			266.23	266.23	157
17		SE1	246.34			238.75		
18		SSC	242.48			234.83	234.83	2
19		SSB	229.62			223.06		
20		SSA	225.77			219.13	219.13	37
21		CC2	241.20			233.52	233.52	2
22		CC1	220.62			215.21	215.21	1
23		CB2	210.32			204.74		
24		CB1	201.32			195.58		
25		CA2	200.03			194.28		
26		CA1	187.17			183.80	183.80	7
27		IB2	179.45			175.95		
28		IB1	176.88			173.34		
29		IA2	162.73			160.26		
30		IA1	156.29			155.02		
31		BB2	178.17			174.65		
32		BB1	173.02			170.72		
33		BA2	161.44			158.95		
34		BA1	151.15			148.49		
35		PE2	193.60			189.04		
36		PE1	189.75			186.43		
37		PD2	184.60			179.88		
38		PD1	182.03			177.27		
39		PC2	175.59			172.03		
40		PC1	173.02			170.72		
41		PB2	155.01			153.72		
42		PB1	153.72			151.10	151.10	1
43		PA2	152.43			149.79		
44		PA1	148.58			145.87	145.87	14
45		AAA	148.58			145.87		
45	.01	ES3						
45	.02	ES2						
45	.03	ES1						
45	.04	HE2						
45	.05	HE1						
45	.06	HD2						
45	.07	HD1						
45	.08	HC2						
45	.09	HC1						
45	.10	HB2						
45	.11	HB1						
45	.12	LE2						
45	.13	LE1						
45	.14	LD2						
45	.15	LD1						
45	.16	LC2						
45	.17	LC1						
45	.18	LB2						
45	.19	LB1						
45	.20	CE2						
45	.21	CE1						
45	.22	CD1						
45	.23	CD1						
5		TOTAL						2,241

(1) Enter in column 3.01 the days prior to October 1st and in column 4.01 the days on after October 1st. Enter in column 4.03 the days on 4/1/2001 through 9/30/2001. The sum of the days in column 3.01, 4.01, and 4.03 must agree with the days reported on Wkst. S-3, Part I, column 4, line 15. The sum of the days in column 4.06 must agree with the days reported on Wkst S-3, Part I column 4, line 3.

PROSPECTIVE PAYMENT FOR SNF
STATISTICAL DATA

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET S-7 I NOT A CMS WORKSHEET
SERVICES THROUGH 12/31/2005

GROUP(1)	M3PI REVENUE CODE	SERVICES PRIOR TO OCTOBER 1ST BASE RATE	RATE	DAYS	SERVICES ON OR AFTER OCTOBER 1ST BASE RATE	RATE	DAYS
1		3a	3	3.01	4a	4	4.01

Worksheet S-2 reference data:
Transition Period : 100% Federal
Wage Index Factor (before 10/01): 0.8386
Wage Index Factor (after 10/01) : 0.8312
SNF Facility Specific Rate : 256.96
Urban/Rural Designation : RURAL
SNF MSA Code : 14
SNF CBSA Code : 99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

	GROUP(1)	M3PI REVENUE CODE	AIDS DIAGNOSIS CODE 042 SERV PRIOR TO OCT. 1ST RATE	DAYS	SERV ON/AFTEER OCT. 1ST RATE	DAYS	SWING BED SNF DAYS	TOTAL
	1	2	4.02	4.03	4.04	4.05	4.06	5
1		RUC	1,134.98		1,130.36			
2		RUB	1,049.92		1,046.86			37,650
3		RUA	1,005.91		1,005.09			3,086
3	.01	RUX	1,316.81		1,300.40			
3	.02	RUL	1,170.19		1,163.19			27,039
4		RVC	896.31		884.66			5,432
5		RVB	855.27		845.90			44,150
6		RVA	776.09		774.31			77,091
6	.01	RVX	987.24		974.18			31,618
6	.02	RVL	925.66		914.51			68,187
7		RHC	768.04		754.25			43,336
8		RHB	735.80		724.42			82,928
9		RHA	685.92		679.67			40,244
9	.01	RHX	826.73		813.89			
9	.02	RHL	812.04		795.99			
10		RMC	702.22		690.25			2,119
11		RMB	684.62		672.35			21,822
12		RMA	669.96		660.42			11,297
[illegible]	.01	RMX	930.97		908.01			113,103
[illegible]	.02	RML	857.64		839.40			106,398
13		RLB	608.60		595.08			
14		RLA	523.53		514.53			
14	.01	RLX	658.44		642.80			
15		SE3	737.65		708.42			16,778
16		SE2	629.14		607.00			41,798
17		SE1	561.66		544.35			
18		SSC	552.85		535.41			470
19		SSB	523.53		508.58			
20		SSA	514.76		499.62			8,108
21		CC2	549.94		532.43			467
22		CC1	503.01		490.68			215
23		CB2	479.53		466.81			
24		CB1	459.01		445.92			
25		CA2	456.07		442.96			
26		CA1	426.75		419.06			1,287
27		IB2	409.15		401.17			
28		IB1	403.29		395.22			
29		IA2	371.02		365.39			
30		IA1	356.34		353.45			
31		BB2	406.23		398.20			
32		BB1	394.49		389.24			
33		BA2	368.08		362.41			
34		BA1	344.62		338.56			
35		PE2	441.41		431.01			
36		PE1	432.63		425.06			
37		PD2	420.89		410.13			
38		PD1	415.03		404.18			
39		PC2	400.35		392.23			
40		PC1	394.49		389.24			
41		PB2	353.42		350.48			
42		PB1	350.48		344.51			151
43		PA2	347.54		341.52			
44		PA1	338.76		332.58			2,042
45		AAA	338.76		332.58			
45	.01	ES3						
45	.02	ES2						
45	.03	ES1						
45	.04	HE2						
[illegible]	.05	HE1						
[illegible]	.06	HD2						
45	.07	HD1						
45	.08	HC2						
45	.09	HC1						
45	.10	HB2						
45	.11	HB1						
45	.12	LE2						
45	.13	LE1						

		M3PI	AIDS DIAGNOSIS CODE 042				SWING	
	GROUP(1)	REVENUE CODE	SERV PRIOR TO OCT. 1ST RATE	SERV PRIOR TO OCT. 1ST DAYS	SERV ON/AFTEER OCT. 1ST RATE	SERV ON/AFTEER OCT. 1ST DAYS	BED SNF DAYS	TOTAL
	1	2	4.02	4.03	4.04	4.05	4.06	5
45	.14 LD2							
45	.15 LD1							
45	.16 LC2							
45	.17 LC1							
45	.18 LB2							
45	.19 LB1							
45	.20 CE2							
45	.21 CE1							
45	.22 CD1							
45	.23 CD1							
46	TOTAL							786,816

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(2) Enter in column 4.05 those days in either column 3.01 or 4.01 which cover the period of 4/1/2000 through 9/30/2000. These RUGs will be incremented by an additional 20% payment.

(3) Enter in column 4.06 the swing bed days for cost reporting periods beginning on or after 7/1/2002.

(4) Additional Rugs were published in the "Federal Register", Vol. 74 No. 153 August 11,2009, page 40286. FY 2010 SNF Final Rule These RUGs are effective for services on or after 10/01/2010.

NOTE: The default line code designation has been changed to "AAA".

Worksheet S-2 reference data:

Transition Period	:	100% Federal
Wage Index Factor (before 10/01)	:	0.8386
Wage Index Factor (after 10/01)	:	0.8312
SNF Facility Specific Rate	:	256.96
Urban/Rural Designation	:	RURAL
SNF MSA Code	:	14
SNF CBSA Code	:	99914

Non-CMS S-7 options selected:
[x] Calculate Total Days from this worksheet.
[x] Transfer total to settlement worksheet.

PROVIDER-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFIED HEALTH CENTER PROVIDER STATISTICAL DATA

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET S-8
COMPONENT NO:	TO 6/30/2010	
14-8500		

RHC 1

	C ADDRESS AND IDENTIFICATION				
1	STREET: 303 NW 11TH ST				
1.01	CITY: FAIRFIELD	STATE: IL	ZIP CODE: 62837	COUNTY: WAYNE	
2	DESIGNATION (FOR FQHCS ONLY) - ENTER "R" FOR RURAL OR "U" FOR URBAN				R

SOURCE OF FEDERAL FUNDS:	GRANT AWARD 1	DATE 2
3 COMMUNITY HEALTH CENTER (SECTION 339(d), PHS ACT)		/ /
4 MIGRANT HEALTH CENTER (SECTION 329(d), PHS ACT)		/ /
5 HEALTH SERVICES FOR THE HOMELESS (SECTION 340(d), PHS ACT)		/ /
6 APPALACHIAN REGIONAL COMMISSION		/ /
7 LOOK-ALIKES		/ /
8 OTHER (SPECIFY)		/ /

PHYSICIAN INFORMATION:

	PHYSICIAN NAME	BILLING NUMBER
9 PHYSICIAN(S) FURNISHING SERVICES AT THE CLINIC OR UNDER AGREEMENT		

	PHYSICIAN NAME	HOURS OF SUPERVISION
10 SUPERVISORY PHYSICIAN(S) AND HOURS OF SUPERVISION DURING PERIOD		

11 DOES THIS FACILITY OPERATE AS OTHER THAN AN RHC OR FQHC? IF YES, INDICATE NUMBER OF OTHER OPERATIONS IN COLUMN 2 (ENTER IN SUBSCRIPTS OF LINE 12 THE TYPE OF OTHER OPERATION(S) AND THE OPERATING HOURS.) — N

FACILITY HOURS OF OPERATIONS (1)

	TYPE OPERATION	SUNDAY FROM	SUNDAY TO	MONDAY FROM	MONDAY TO	TUESDAY FROM	TUESDAY TO	WEDNESDAY FROM	WEDNESDAY TO	THURSDAY FROM	THURSDAY TO	FRIDAY FROM	FRIDAY TO	SATURDAY FROM	SATURDAY TO
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12	CLINIC			900	500	900	500	900	500	900	500	900	500		

(1) ENTER CLINIC HOURS OF OPERATIONS ON SUBSCRIPTS OF LINE 12 (BOTH TYPE AND HOURS OF OPERATION). LIST HOURS OF OPERATION BASED ON A 24 HOUR CLOCK. FOR EXAMPLE: 8:00AM IS 0800, 6:30PM IS 1830, AND MIDNIGHT IS 2400

13 HAVE YOU RECEIVED AN APPROVAL FOR AN EXCEPTION TO THE PRODUCTIVITY STANDARD? — N

14 IS THIS A CONSOLIDATED COST REPORT DEFINED IN THE RURAL HEALTH CLINIC MANUAL? IF YES, ENTER IN COLUMN 2 THE NUMBER OF PROVIDERS INCLUDED IN THIS REPORT, COMPLETE LINE 15 AND COMPLETE ONLY ONE WORKSHEET SERIES M FOR THE CONSOLIDATED GROUP. IF NO, COMPLETE A SEPARATE WORKSHEET S-8 FOR EACH COMPONENT ACCOMPANIED BY A CORRESPONDING WORKSHEET M SERIES. — N

15 PROVIDER NAME: FAIRFIELD RHC I PROVIDER NUMBER:

		TITLE V	TITLE XVIII	TITLE XIX
16	HAVE YOU PROVIDED ALL OR SUBSTANTIALLY ALL GME COSTS. IF YES, ENTER IN COLUMNS 2, 3, AND 4 THE NUMBER OF PROGRAM VISITS PERFORMED BY INTERNS & RESIDENTS.	N		
17	HAS THE HOSPITALS' BED SIZE CHANGED TO LESS THAN 50 BEDS DURING THE YEAR FOR COST REPORTING PERIODS OVERLAPPING 7/1/2001? IF YES, SEE INSTRUCTIONS.			N

HOSPITAL UNCOMPENSATED CARE DATA | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/15/2010 WORKSHEET S-10

	DESCRIPTION	
	UNCOMPENSATED CARE INFORMATION	
1	DO YOU HAVE A WRITTEN CHARITY CARE POLICY?	
2	ARE PATIENTS WRITE-OFFS IDENTIFIED AS CHARITY? IF YES ANSWER LINES 2.01 THRU 2.04	
2.01	IS IT AT THE TIME OF ADMISSION?	
2.02	IS IT AT THE TIME OF FIRST BILLING?	
2.03	IS IT AFTER SOME COLLECTION EFFORT HAS BEEN MADE?	
2.04	Other methods of write-offs (speci	
3	ARE CHARITY WRITE-OFFS MADE FOR PARTIAL BILLS?	
4	ARE CHARITY DETERMINATIONS BASED UPON ADMINISTRATIVE JUDGMENT WITHOUT FINANCIAL DATA?	
5	ARE CHARITY DETERMINATIONS BASED UPON INCOME DATA ONLY?	
6	ARE CHARITY DETERMINATIONS BASED UPON NET WORTH (ASSETS) DATA?	
7	ARE CHARITY DETERMINATIONS BASED UPON INCOME AND NET WORTH DATA?	
8	DOES YOUR ACCOUNTING SYSTEM SEPARATELY IDENTIFY BAD DEBT AND CHARITY CARE? IF YES ANSWER 8.01	
8.01	DO YOU SEPARATELY ACCOUNT FOR INPATIENT AND OUTPATIENT SERVICES?	
9	IS DISCERNING CHARITY FROM BAD DEBT A HIGH PRIORITY IN YOUR INSTITUTION? IF NO ANSWER 9.01 THRU 9.04	
9.01	IS IT BECAUSE THERE IS NOT ENOUGH STAFF TO DETERMINE ELIGIBILITY?	
9.02	IS IT BECAUSE THERE IS NO FINANCIAL INCENTIVE TO SEPARATE CHARITY FROM BAD DEBT?	
9.03	IS IT BECAUSE THERE IS NO CLEAR DIRECTIVE POLICY ON CHARITY DETERMINATION?	
9.04	IS IT BECAUSE YOUR INSTITUTION DOES NOT DEEM THE DISTINCTION IMPORTANT?	
10	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, WHAT IS THE MAXIMUM INCOME THAT CAN BE EARNED BY PATIENTS (SINGLE WITHOUT DEPENDENT) AND STILL DETERMINED TO BE A CHARITY WRITE OFF?	
11	IF CHARITY DETERMINATIONS ARE MADE BASED UPON INCOME DATA, IS THE INCOME DIRECTLY TIED TO FEDERAL POVERTY LEVEL? IF YES ANSWER 11.01 THRU 11.04	
11.01	IS THE PERCENTAGE LEVEL USED LESS THAN 100% OF THE FEDERAL POVERTY LEVEL?	
11.02	IS THE PERCENTAGE LEVEL USED BETWEEN 100% AND 150% OF THE FEDERAL POVERTY LEVEL?	
11.03	IS THE PERCENTAGE LEVEL USED BETWEEN 150% AND 200% OF THE FEDERAL POVERTY LEVEL?	
11.04	IS THE PERCENTAGE LEVEL USED GREATER THAN 200% OF THE FEDERAL POVERTY LEVEL?	
12	ARE PARTIAL WRITE-OFFS GIVEN TO HIGHER INCOME PATIENTS ON A GRADUAL SCALE?	
13	IS THERE CHARITY CONSIDERATION GIVEN TO HIGH NET WORTH PATIENTS WHO HAVE CATASTROPHIC OR OTHER EXTRAORDINARY MEDICAL EXPENSES?	
14	IS YOUR HOSPITAL STATE OR LOCAL GOVERNMENT OWNED? IF YES ANSWER LINES 14.01 AND 14.02	
14.01	DO YOU RECEIVE DIRECT FINANCIAL SUPPORT FROM THAT GOVERNMENT ENTITY FOR THE PURPOSE OF PROVIDING COMPENSATED CARE?	
14.02	WHAT PERCENTAGE OF THE AMOUNT ON LINE 14.01 IS FROM GOVERNMENT FUNDING?	
15	DO YOU RECEIVE RESTRICTED GRANTS FOR RENDERING CARE TO CHARITY PATIENTS?	
16	ARE OTHER NON-RESTRICTED GRANTS USED TO SUBSIDIZE CHARITY CARE?	
	UNCOMPENSATED CARE REVENUES	
17	REVENUE FROM UNCOMPENSATED CARE	28,761
17.01	GROSS MEDICAID REVENUES	1,996,785
18	REVENUES FROM STATE AND LOCAL INDIGENT CARE PROGRAMS	
19	REVENUE RELATED TO SCHIP (SEE INSTRUCTIONS)	
20	RESTRICTED GRANTS	
21	NON-RESTRICTED GRANTS	
22	TOTAL GROSS UNCOMPENSATED CARE REVENUES	2,025,546
	UNCOMPENSATED CARE COST	
23	TOTAL CHARGES FOR PATIENTS COVERED BY STATE AND LOCAL INDIGENT CARE PROGRAMS	
24	COST TO CHARGE RATIO (WKST C, PART I, COLUMN 3, LINE 103, DIVIDED BY COLUMN 8, LINE 103)	.435433
25	TOTAL STATE AND LOCAL INDIGENT CARE PROGRAM COST (LINE 23 * LINE 24)	
26	TOTAL SCHIP CHARGES FROM YOUR RECORDS	
27	TOTAL SCHIP COST, (LINE 24 * LINE 26)	
28	TOTAL GROSS MEDICAID CHARGES FROM YOUR RECORDS	7,765,320

	DESCRIPTION	
29	TOTAL GROSS MEDICAID COST (LINE 24 * LINE 28)	3,381,277
30	OTHER UNCOMPENSATED CARE CHARGES FROM YOUR RECORDS	
31	UNCOMPENSATED CARE COST (LINE 24 * LINE 30)	
32	TOTAL UNCOMPENSATED CARE COST TO THE HOSPITAL (SUM OF LINES 25, 27, AND 29)	3,381,277

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET A

	COST CENTER	COST CENTER DESCRIPTION	SALARIES	OTHER	TOTAL	RECLASS-IFICATIONS	RECLASSIFIED TRIAL BALANCE
			1	2	3	4	5
		GENERAL SERVICE COST CNTR					
3	0300	NEW CAP REL COSTS-BLDG & FIXT		767,349	767,349		767,349
4	0400	NEW CAP REL COSTS-MVBLE EQUIP				444,060	444,060
5	0500	EMPLOYEE BENEFITS	61,998	2,144,992	2,206,990		2,206,990
6	0600	ADMINISTRATIVE & GENERAL	845,102	1,900,635	2,745,737	123,933	2,869,670
7	0700	MAINTENANCE & REPAIRS	209,310	230,985	440,295	-1,225	439,070
8	0800	OPERATION OF PLANT		388,695	388,695		388,695
9	0900	LAUNDRY & LINEN SERVICE		205,598	205,598		205,598
10	1000	HOUSEKEEPING	234,760	106,971	341,731		341,731
11	1100	DIETARY	192,880	284,248	477,128	-214,338	262,790
12	1200	CAFETERIA				212,682	212,682
14	1400	NURSING ADMINISTRATION	127,347	9,604	136,951		136,951
17	1700	MEDICAL RECORDS & LIBRARY	247,160	52,040	299,200	-919	298,281
18	1800	SOCIAL SERVICE	67,347	5,627	72,974		72,974
		INPAT ROUTINE SRVC CNTRS					
25	2500	ADULTS & PEDIATRICS	1,133,120	51,367	1,184,487		1,184,487
26	2600	INTENSIVE CARE UNIT	190,479	9,519	199,998		199,998
33	3300	NURSERY					
34	3400	SKILLED NURSING FACILITY	550,290	41,652	591,942	-4,364	587,578
35	3500	NURSING FACILITY	1,884,923	1,621,260	3,506,183		3,506,183
		ANCILLARY SRVC COST CNTRS					
37	3700	OPERATING ROOM	950,462	261,442	1,211,904		1,211,904
39	3900	DELIVERY ROOM & LABOR ROOM					
41	4100	RADIOLOGY-DIAGNOSTIC	411,430	1,173,816	1,585,246	-302,697	1,282,549
44	4400	LABORATORY	730,725	1,099,387	1,830,112	-68,367	1,761,745
49	4900	RESPIRATORY THERAPY	139,697	128,259	267,956	-91,959	175,997
50	5000	PHYSICAL THERAPY	675,103	22,909	698,012	-228	697,784
53	5300	ELECTROCARDIOLOGY				76,024	76,024
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS	43,393	751,437	794,830	135	794,965
56	5600	DRUGS CHARGED TO PATIENTS	213,293	812,038	1,025,331		1,025,331
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	180,992	126,339	307,331		307,331
		OUTPAT SERVICE COST CNTRS					
61	6100	EMERGENCY	663,832	1,267,866	1,931,698	-3,764	1,927,934
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)					
63	4950	OTHER OUTPATIENT SERVICE COST CENTER					
63.50	6310	RURAL HEALTH CLINIC	1,339,259	334,208	1,673,467	-5,672	1,667,795
		OTHER REIMBURS COST CNTRS					
71	7100	HOME HEALTH AGENCY	266,110	71,941	338,051	135	338,186
		SPEC PURPOSE COST CENTERS					
	8800	INTEREST EXPENSE		183,404	183,404	-163,436	19,968
95		SUBTOTALS	11,359,012	14,053,588	25,412,600	-0-	25,412,600
		NONREIMBURS COST CENTERS					
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN					
100	7950	DR. OFFICE					
101		TOTAL	11,359,012	14,053,588	25,412,600	-0-	25,412,600

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

	COST CENTER	COST CENTER DESCRIPTION	ADJUSTMENTS	NET EXPENSES FOR ALLOC
			6	7
		GENERAL SERVICE COST CNTR		
3	0300	NEW CAP REL COSTS-BLDG & FIXT	-107,533	659,816
4	0400	NEW CAP REL COSTS-MVBLE EQUIP	-608	443,452
5	0500	EMPLOYEE BENEFITS		2,206,990
6	0600	ADMINISTRATIVE & GENERAL	-176,343	2,693,327
7	0700	MAINTENANCE & REPAIRS		439,070
8	0800	OPERATION OF PLANT		388,695
9	0900	LAUNDRY & LINEN SERVICE		205,598
10	1000	HOUSEKEEPING		341,731
11	1100	DIETARY		262,790
12	1200	CAFETERIA	-134,968	77,714
14	1400	NURSING ADMINISTRATION		136,951
17	1700	MEDICAL RECORDS & LIBRARY	-8,636	289,645
18	1800	SOCIAL SERVICE		72,974
		INPAT ROUTINE SRVC CNTRS		
25	2500	ADULTS & PEDIATRICS		1,184,487
26	2600	INTENSIVE CARE UNIT		199,998
33	3300	NURSERY		
34	3400	SKILLED NURSING FACILITY		587,578
35	3500	NURSING FACILITY		3,506,183
		ANCILLARY SRVC COST CNTRS		
37	3700	OPERATING ROOM	-429,533	782,371
39	3900	DELIVERY ROOM & LABOR ROOM		
41	4100	RADIOLOGY-DIAGNOSTIC	-20,351	1,262,198
44	4400	LABORATORY		1,761,745
49	4900	RESPIRATORY THERAPY		175,997
50	5000	PHYSICAL THERAPY		697,784
53	5300	ELECTROCARDIOLOGY	-38,935	37,089
55	5500	MEDICAL SUPPLIES CHARGED TO PATIENTS		794,965
56	5600	DRUGS CHARGED TO PATIENTS		1,025,331
59	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		307,331
		OUTPAT SERVICE COST CNTRS		
61	6100	EMERGENCY	-782,745	1,145,189
62	6200	OBSERVATION BEDS (NON-DISTINCT PART)		
63	4950	OTHER OUTPATIENT SERVICE COST CENTER		
63.50	6310	RURAL HEALTH CLINIC		1,667,795
		OTHER REIMBURS COST CNTRS		
71	7100	HOME HEALTH AGENCY		338,186
		SPEC PURPOSE COST CENTERS		
	8800	INTEREST EXPENSE	-19,968	-0-
[illegible]		SUBTOTALS	-1,719,620	23,692,980
		NONREIMBURS COST CENTERS		
96	9600	GIFT, FLOWER, COFFEE SHOP & CANTEEN		
100	7950	DR. OFFICE		
101		TOTAL	-1,719,620	23,692,980

COST CENTERS USED IN COST REPORT

LINE NO.	COST CENTER DESCRIPTION	CMS CODE	STANDARD LABEL FOR NON-STANDARD CODES
	GENERAL SERVICE COST		
	NEW CAP REL COSTS-BLDG & FIXT	0300	
4	NEW CAP REL COSTS-MVBLE EQUIP	0400	
5	EMPLOYEE BENEFITS	0500	
6	ADMINISTRATIVE & GENERAL	0600	
7	MAINTENANCE & REPAIRS	0700	
8	OPERATION OF PLANT	0800	
9	LAUNDRY & LINEN SERVICE	0900	
10	HOUSEKEEPING	1000	
11	DIETARY	1100	
12	CAFETERIA	1200	
14	NURSING ADMINISTRATION	1400	
17	MEDICAL RECORDS & LIBRARY	1700	
18	SOCIAL SERVICE	1800	
	INPAT ROUTINE SRVC C		
25	ADULTS & PEDIATRICS	2500	
26	INTENSIVE CARE UNIT	2600	
33	NURSERY	3300	
34	SKILLED NURSING FACILITY	3400	
35	NURSING FACILITY	3500	
	ANCILLARY SRVC COST		
37	OPERATING ROOM	3700	
39	DELIVERY ROOM & LABOR ROOM	3900	
41	RADIOLOGY-DIAGNOSTIC	4100	
44	LABORATORY	4400	
49	RESPIRATORY THERAPY	4900	
50	PHYSICAL THERAPY	5000	
53	ELECTROCARDIOLOGY	5300	
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	5500	
56	DRUGS CHARGED TO PATIENTS	5600	
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	3550	PSYCHIATRIC/PSYCHOLOGICAL SERVICES
	OUTPAT SERVICE COST		
61	EMERGENCY	6100	
62	OBSERVATION BEDS (NON-DISTINCT PART)	6200	
63	OTHER OUTPATIENT SERVICE COST CENTER	4950	OTHER OUTPATIENT SERVICE COST CENTER
63.50	RURAL HEALTH CLINIC	6310	RURAL HEALTH CLINIC #####
	OTHER REIMBURS COST		
71	HOME HEALTH AGENCY	7100	
	SPEC PURPOSE COST CE		
[illegible]8	INTEREST EXPENSE	8800	
	SUBTOTALS		OLD CAP REL COSTS-BLDG & FIXT
	NONREIMBURS COST CEN		
96	GIFT, FLOWER, COFFEE SHOP & CANTEEN	9600	
100	DR. OFFICE	7950	OTHER NONREIMBURSABLE COST CENTERS
101	TOTAL		OLD CAP REL COSTS-BLDG & FIXT

	EXPLANATION OF RECLASSIFICATION	INCREASE CODE (1)	COST CENTER	LINE NO	SALARY	OTHER
		1	2	3	4	5
1	CAFETERIA	A	CAFETERIA	12	85,977	126,705
2	EKG	C	ELECTROCARDIOLOGY	53	37,089	38,935
3	RENTAL	D	NEW CAP REL COSTS-MVBLE EQUIP	4		444,060
4						
5						
6						
7						
8						
9						
10						
11						
12			MEDICAL SUPPLIES CHARGED TO PATIENTS	55		135
13						
14						
15			HOME HEALTH AGENCY	71		135
16	INTEREST	E	ADMINISTRATIVE & GENERAL	6		163,436
36	TOTAL RECLASSIFICATIONS				123,066	773,406

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

	EXPLANATION OF RECLASSIFICATION	DECREASE CODE (1)	DECREASE COST CENTER 6	DECREASE LINE NO 7	DECREASE SALARY 8	DECREASE OTHER 9	A-7 REF 10
1	CAFETERIA	A	DIETARY	11	85,977	126,705	
2	EKG	C	RESPIRATORY THERAPY	49	37,089	38,935	
3	RENTAL	D	ADMINISTRATIVE & GENERAL	6		39,503	10
4			MAINTENANCE & REPAIRS	7		1,225	
5			DIETARY	11		1,656	
6			MEDICAL RECORDS & LIBRARY	17		919	
7			SKILLED NURSING FACILITY	34		4,364	
8			RADIOLOGY-DIAGNOSTIC	41		302,697	
9			LABORATORY	44		68,367	
10			RESPIRATORY THERAPY	49		15,935	
11			PHYSICAL THERAPY	50		228	
12							
13			EMERGENCY	61		3,764	
14			RURAL HEALTH CLINIC	63.50		5,672	
15							
16	INTEREST	E	INTEREST EXPENSE	88		163,436	
36	TOTAL RECLASSIFICATIONS				123,066	773,406	

(1) A letter (A, B, etc) must be entered on each line to identify each reclassification entry.
Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.
See instructions for column 10 referencing to Worksheet A-7, Part III, columns 9 through 14.

RECLASS CODE: A
EXPLANATION : CAFETERIA

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	CAFETERIA	12	212,682	DIETARY	11	212,682
TOTAL RECLASSIFICATIONS FOR CODE A			212,682			212,682

RECLASS CODE: C
EXPLANATION : EKG

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ELECTROCARDIOLOGY	53	76,024	RESPIRATORY THERAPY	49	76,024
TOTAL RECLASSIFICATIONS FOR CODE C			76,024			76,024

RECLASS CODE: D
EXPLANATION : RENTAL

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	NEW CAP REL COSTS-MVBLE EQUIP	4	444,060	ADMINISTRATIVE & GENERAL	6	39,503
2.00			0	MAINTENANCE & REPAIRS	7	1,225
3.00			0	DIETARY	11	1,656
4.00			0	MEDICAL RECORDS & LIBRARY	17	919
6.00			0	SKILLED NURSING FACILITY	34	4,364
7.00			0	RADIOLOGY-DIAGNOSTIC	41	302,697
8.00			0	LABORATORY	44	68,367
9.00			0	RESPIRATORY THERAPY	49	15,935
10.00			0	PHYSICAL THERAPY	50	228
11.00	MEDICAL SUPPLIES CHARGED TO PA	55	135			0
12.00			0	EMERGENCY	61	3,764
13.00			0	RURAL HEALTH CLINIC	63.50	5,672
14.00	HOME HEALTH AGENCY	71	135			0
TOTAL RECLASSIFICATIONS FOR CODE D			444,330			444,330

RECLASS CODE: E
EXPLANATION : INTEREST

INCREASE				DECREASE		
LINE	COST CENTER	LINE	AMOUNT	COST CENTER	LINE	AMOUNT
1.00	ADMINISTRATIVE & GENERAL	6	163,436	INTEREST EXPENSE	88	163,436
TOTAL RECLASSIFICATIONS FOR CODE E			163,436			163,436

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)
ANALYSIS OF CHANGES DURING COST REPORTING PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED TO PARTICIPATE IN HEALTH CARE PROGRAMS
PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2009 TO 6/30/2010 PREPARED 11/15/2010
WORKSHEET A-7 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND							
2	LAND IMPROVEMENTS							
3	BUILDINGS & FIXTURE							
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT							
6	MOVABLE EQUIPMENT							
7	SUBTOTAL							
8	RECONCILING ITEMS							
9	TOTAL							

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

	DESCRIPTION	BEGINNING BALANCES 1	ACQUISITIONS PURCHASES 2	ACQUISITIONS DONATION 3	ACQUISITIONS TOTAL 4	DISPOSALS AND RETIREMENTS 5	ENDING BALANCE 6	FULLY DEPRECIATED ASSETS 7
1	LAND	248,648	64,137		64,137		312,785	
2	LAND IMPROVEMENTS	330,882	144,055		144,055		474,937	
3	BUILDINGS & FIXTURE	13,465,272	3,199,135		3,199,135		16,664,407	
4	BUILDING IMPROVEMEN							
5	FIXED EQUIPMENT	696,495	44,905		44,905		741,400	
6	MOVABLE EQUIPMENT	7,451,378	828,427		828,427		8,279,805	
7	SUBTOTAL	22,192,675	4,280,659		4,280,659		26,473,334	
8	RECONCILING ITEMS							
9	TOTAL	22,192,675	4,280,659		4,280,659		26,473,334	

III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS GROSS ASSETS	CAPITLIZED GROSS ASSETS LEASES	FOR RATIO	RATIO	ALLOCATION OF OTHER CAPITAL INSURANCE	TAXES	OTHER CAPITAL RELATED COSTS	TOTAL
*		1	2	3	4	5	6	7	8
3	NEW CAP REL COSTS-BL	18,193,529		18,193,529	.687240				
4	NEW CAP REL COSTS-MV	8,279,805		8,279,805	.312760				
5	TOTAL	26,473,334		26,473,334	1.000000				

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	731,232	-71,416					659,816
4	NEW CAP REL COSTS-MV	-608	444,060					443,452
5	TOTAL	730,624	372,644					1,103,268

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

	DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES	OTHER CAPITAL RELATED COST	TOTAL (1)
*		9	10	11	12	13	14	15
3	NEW CAP REL COSTS-BL	767,349						767,349
4	NEW CAP REL COSTS-MV							
5	TOTAL	767,349						767,349

* All lines numbers except line 5 are to be consistent with Workhseet A line numbers for capital cost centers.
(1) The amounts on lines 1 thru 4 must equal the corresponding amounts on Worksheet A, column 7, lines 1 thru 4.
Columns 9 through 14 should include related Worksheet A-6 reclassifications and Worksheet A-8 adjustments. (See instructions).

ADJUSTMENTS TO EXPENSES

	DESCRIPTION (1)	(2) BASIS/CODE 1	AMOUNT 2	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED COST CENTER 3	LINE NO 4	WKST. A-7 REF. 5
1	INVST INCOME-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
2	INVESTMENT INCOME-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
3	INVST INCOME-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
4	INVESTMENT INCOME-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
5	INVESTMENT INCOME-OTHER	B	-19,968	INTEREST EXPENSE	88	
6	TRADE, QUANTITY AND TIME DISCOUNTS					
7	REFUNDS AND REBATES OF EXPENSES					
8	RENTAL OF PRVIDER SPACE BY SUPPLIERS					
9	TELEPHONE SERVICES	A	-4,658	ADMINISTRATIVE & GENERAL	6	
10	TELEVISION AND RADIO SERVICE					
11	PARKING LOT					
12	PROVIDER BASED PHYSICIAN ADJUSTMENT	A-8-2	-1,251,213			
13	SALE OF SCRAP, WASTE, ETC.					
14	RELATED ORGANIZATION TRANSACTIONS	A-8-1	-20,351			
15	LAUNDRY AND LINEN SERVICE					
16	CAFETERIA--EMPLOYEES AND GUESTS	B	-134,968	CAFETERIA	12	
17	RENTAL OF QTRS TO EMPLYEE AND OTHRS					
18	SALE OF MED AND SURG SUPPLIES					
19	SALE OF DRUGS TO OTHER THAN PATIENTS					
20	SALE OF MEDICAL RECORDS & ABSTRACTS	B	-8,636	MEDICAL RECORDS & LIBRARY	17	
21	NURSG SCHOOL(TUITN,FEES,BOOKS, ETC.)					
22	VENDING MACHINES					
23	INCOME FROM IMPOSITION OF INTEREST					
24	INTRST EXP ON MEDICARE OVERPAYMENTS					
25	ADJUSTMENT FOR RESPIRATORY THERAPY	A-8-3/A-8-4		RESPIRATORY THERAPY	49	
26	ADJUSTMENT FOR PHYSICAL THERAPY	A-8-3/A-8-4		PHYSICAL THERAPY	50	
27	ADJUSTMENT FOR HHA PHYSICAL THERAPY	A-8-3				
28	UTILIZATION REVIEW-PHYSIAN COMP			**COST CENTER DELETED**	89	
29	DEPRECIATION-OLD BLDGS AND FIXTURES			**COST CENTER DELETED**	1	
30	DEPRECIATION-OLD MOVABLE EQUIP			**COST CENTER DELETED**	2	
31	DEPRECIATION-NEW BLDGS AND FIXTURES			NEW CAP REL COSTS-BLDG &	3	
32	DEPRECIATION-NEW MOVABLE EQUIP			NEW CAP REL COSTS-MVBLE E	4	
33	NON-PHYSICIAN ANESTHETIST			**COST CENTER DELETED**	20	
34	PHYSICIANS' ASSISTANT					
35	ADJUSTMENT FOR OCCUPATIONAL THERAPY	A-8-4		**COST CENTER DELETED**	51	
36	ADJUSTMENT FOR SPEECH PATHOLOGY	A-8-4		**COST CENTER DELETED**	52	
37	OFFICE SPACE	B	-71,416	NEW CAP REL COSTS-BLDG &	3	10
	BABY PICS					
39						
40	PRENATAL CLASS					
41	RINARD & WEBER	A	-36,117	NEW CAP REL COSTS-BLDG &	3	9
42	RECRUITING	A	-8,469	ADMINISTRATIVE & GENERAL	6	
43	ADVERTISING	A	-158,917	ADMINISTRATIVE & GENERAL	6	
44	MISC REV	B	-4,299	ADMINISTRATIVE & GENERAL	6	
45	LIFELINE	B	-608	NEW CAP REL COSTS-MVBLE E	4	9
46	OTHER ADJUSTMENTS (SPECIFY)					
47	OTHER ADJUSTMENTS (SPECIFY)					
48	OTHER ADJUSTMENTS (SPECIFY)					
49	OTHER ADJUSTMENTS (SPECIFY)					
50	TOTAL (SUM OF LINES 1 THRU 49)		-1,719,620			

(1) Description - all chapter references in this columnpertain to CMS Pub. 15-I.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 37 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT	NET* ADJUST-MENTS	WKSHT A-7 COL. REF.
	1	2	3	4	5	6	
1	41 RADIOLOGY-DIAGNOSTIC	MRI	218,782	239,133	-20,351	
2						
3						
4						
5	TOTALS		218,782	239,133	-20,351	

* THE AMOUNTS ON LINES 1-4 AND SUBSCRIPTS AS APPROPRIATE ARE TRANSFERRED IN DETAIL TO WORKSHEET A, COLUMN 6, LINES AS APPROPRIATE. POSITIVE AMOUNTS INCREASE COST AND NEGATIVE AMOUNTS DECREASE COST. FOR RELATED ORGANIZATIONAL OR HOME OFFICE COST WHICH HAS NOT BEEN POSTED TO WORKSHEET A, COLUMNS 1 AND/OR 2, THE AMOUNT ALLOWABLE SHOULD BE IN COLUMN 4 OF THIS PART.

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:
THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(B)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THIS INFORMATION IS USED BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
1	G	DIAGNOSTIC SHARED SERVICE	15.00		0.00	
2			0.00		0.00	
3			0.00		0.00	
4			0.00		0.00	
5			0.00		0.00	

(1) USE THE FOLLOWING SYMBOLS TO INDICATE INTERELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
- B. CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
- C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP OR OTHER ORGANIZATION.
- D. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS A FINANCIAL INTEREST IN RELATED ORGANIZATION.
- E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
- F. DIRECTOR, OFFICER, ADMINISTRATOR OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
- G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY.
  OTHER

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 1	COST CENTER/ PHYSICIAN IDENTIFIER 2	TOTAL REMUN-ERATION 3	PROFES-SIONAL COMPONENT 4	PROVIDER COMPONENT 5	RCE AMOUNT 6	PHYSICIAN/ PROVIDER COMPONENT HOURS 7	UNADJUSTED RCE LIMIT 8	5 PERCENT OF UNADJUSTED RCE LIMIT 9
1	37	ANESTHESIA	429,533	429,533					
2	44	LAB	30,000		30,000				
3	53	EKG	38,935	38,935					
4	61	ER	1,171,949	782,745	389,204				
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
25									
26									
27									
28									
29									
30									
101		TOTAL	1,670,417	1,251,213	419,204				

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(9/1996)

PROVIDER BASED PHYSICIAN ADJUSTMENTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET A-8-2 I GROUP 1

	WKSHT A LINE NO. 10		COST CENTER/ PHYSICIAN IDENTIFIER 11	COST OF MEMBERSHIPS & CONTINUING EDUCATION 12	PROVIDER COMPONENT SHARE OF COL 12 13	PHYSICIAN COST OF MALPRACTICE INSURANCE 14	PROVIDER COMPONENT SHARE OF COL 14 15	ADJUSTED RCE LIMIT 16	RCE DIS-ALLOWANCE 17	ADJUSTMENT 18
1	37	ANESTHESIA								429,533
2	44	LAB								
3	53	EKG								38,935
4	61	ER								782,745
5										
6										
7										
8										
9										
10										
11										
12										
13										
14										
15										
16										
17										
18										
19										
20										
21										
22										
23										
24										
25										
26										
27										
28										
29										
30										
101		TOTAL								1,251,213

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(7/2009)

COST ALLOCATION STATISTICS

I PROVIDER NO: I PERIOD: I PREPARED 11/15/2010
I 14-1311 I FROM 7/ 1/2009 I NOT A CMS WORKSHEET
I I TO 6/30/2010 I

LINE NO.	COST CENTER DESCRIPTION	STATISTICS CODE	STATISTICS DESCRIPTION	
	GENERAL SERVICE COST			
	NEW CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	ENTERED
	NEW CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	ENTERED
5	EMPLOYEE BENEFITS	5	GROSS SALARIES	ENTERED
6	ADMINISTRATIVE & GENERAL	#	ACCUM. COST	NOT ENTERED
7	MAINTENANCE & REPAIRS	1	SQUARE FEET	ENTERED
8	OPERATION OF PLANT	1	SQUARE FEET	ENTERED
9	LAUNDRY & LINEN SERVICE	8	POUNDS OF LAUNDRY	ENTERED
10	HOUSEKEEPING	1	SQUARE FEET	ENTERED
11	DIETARY	10	MEALS SERVED	ENTERED
12	CAFETERIA	11	PAID HOURS	ENTERED
14	NURSING ADMINISTRATION	13	DIRECT NRSING HRS	ENTERED
17	MEDICAL RECORDS & LIBRARY	14	GROSS REV	ENTERED
18	SOCIAL SERVICE	17	TIME SPENT	ENTERED

		COST CENTER DESCRIPTION	NET EXPENSES FOR COST ALLOCATION	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	EMPLOYEE BENEFITS	SUBTOTAL	ADMINISTRATIV E & GENERAL	MAINTENANCE & REPAIRS
			0	3	4	5	5a.00	6	7
		GENERAL SERVICE COST CNTR							
003		NEW CAP REL COSTS-BLDG &	659,816	659,816					
004		NEW CAP REL COSTS-MVBLE E	443,452		443,452				
005		EMPLOYEE BENEFITS	2,206,990			2,206,990			
006		ADMINISTRATIVE & GENERAL	2,693,327	57,084	38,365	198,164	2,986,940	2,986,940	
007		MAINTENANCE & REPAIRS	439,070	25,858	17,378	49,080	531,386	92,281	623,667
008		OPERATION OF PLANT	388,695	16,901	11,359		416,955	72,409	18,271
009		LAUNDRY & LINEN SERVICE	205,598	11,678	7,849		225,125	39,095	12,625
010		HOUSEKEEPING	341,731	1,616	1,086	55,048	399,481	69,374	1,747
011		DIETARY	262,790	4,246	2,853	25,067	294,956	51,222	4,590
012		CAFETERIA	77,714	4,520	3,038	20,160	105,432	18,309	4,886
014		NURSING ADMINISTRATION	136,951	1,169	785	29,861	168,766	29,308	1,264
017		MEDICAL RECORDS & LIBRARY	289,645	10,098	6,787	57,955	364,485	63,297	10,917
018		SOCIAL SERVICE	72,974	1,461	982	15,792	91,209	15,839	1,579
		INPAT ROUTINE SRVC CNTRS							
025		ADULTS & PEDIATRICS	1,184,487	133,295	89,586	265,700	1,673,068	290,547	144,110
026		INTENSIVE CARE UNIT	199,998	12,171	8,180	44,664	265,013	46,022	13,158
033		NURSERY		3,095	2,080		5,175	899	3,346
034		SKILLED NURSING FACILITY	587,578	78,093	52,485	129,035	847,191	147,124	84,428
035		NURSING FACILITY	3,506,183				3,506,183		
		ANCILLARY SRVC COST CNTRS							
037		OPERATING ROOM	782,371	59,275	39,838	222,869	1,104,353	191,783	64,083
039		DELIVERY ROOM & LABOR ROO							
041		RADIOLOGY-DIAGNOSTIC	1,262,198	41,799	28,093	96,474	1,428,564	248,086	45,190
044		LABORATORY	1,761,745	20,708	13,918	171,344	1,967,715	341,715	22,388
049		RESPIRATORY THERAPY	175,997	15,376	10,334	24,060	225,767	39,207	16,623
050		PHYSICAL THERAPY	697,784	32,952	22,147	158,302	911,185	158,237	35,625
053		ELECTROCARDIOLOGY	37,089			8,697	45,786	7,951	
055		MEDICAL SUPPLIES CHARGED	794,965	16,216	10,898	10,175	832,254	144,530	17,531
056		DRUGS CHARGED TO PATIENTS	1,025,331	24,908	16,740	50,014	1,116,993	193,978	26,928
059		PSYCHIATRIC/PSYCHOLOGICAL	307,331	15,841	10,647	42,440	376,259	65,342	17,126
		OUTPAT SERVICE COST CNTRS							
061		EMERGENCY	1,145,189	21,201	14,249	155,659	1,336,298	232,063	22,921
062		OBSERVATION BEDS (NON-DIS							
063		OTHER OUTPATIENT SERVICE							
063	50	RURAL HEALTH CLINIC	1,667,795	32,724	21,993	314,031	2,036,543	353,665	35,378
		OTHER REIMBURS COST CNTRS							
[illegible]		HOME HEALTH AGENCY	338,186	17,531	11,782	62,399	429,898	74,657	18,953
		SPEC PURPOSE COST CENTERS							
[illegible]		SUBTOTALS	23,692,980	659,816	443,452	2,206,990	23,692,980	2,986,940	623,667
		NONREIMBURS COST CENTERS							
096		GIFT, FLOWER, COFFEE SHOP							
100		DR. OFFICE							
101		CROSS FOOT ADJUSTMENT							
102		NEGATIVE COST CENTER							
103		TOTAL	23,692,980	659,816	443,452	2,206,990	23,692,980	2,986,940	623,667

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LIN EN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMIN ISTRATION	MEDICAL RECOR DS & LIBRARY
		8	9	10	11	12	14	17
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	507,635						
009	LAUNDRY & LINEN SERVICE	10,586	287,431					
010	HOUSEKEEPING	1,465	7,782	479,849				
011	DIETARY	3,849	4,323	3,727	362,667			
012	CAFETERIA	4,097	4,192	3,967		140,883		
014	NURSING ADMINISTRATION	1,059		1,026		1,572	202,995	
017	MEDICAL RECORDS & LIBRARY	9,154		8,864		6,037		462,754
018	SOCIAL SERVICE	1,324		1,282		1,551		
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	120,840	86,446	117,002	107,223	18,050	76,748	31,505
026	INTENSIVE CARE UNIT	11,033	6,594	10,683	12,456	2,531	10,760	4,286
033	NURSERY	2,806	10,872	2,717				
034	SKILLED NURSING FACILITY	70,794	121,934	68,546	242,988	11,551	49,115	7,529
035	NURSING FACILITY					48,186		
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	53,735	23,649	52,029		6,881	29,259	33,146
039	DELIVERY ROOM & LABOR ROO							
041	RADIOLOGY-DIAGNOSTIC	37,893		36,690		6,146		114,221
044	LABORATORY	18,772		18,176		12,346		79,892
049	RESPIRATORY THERAPY	13,939		13,496		1,717		25,696
050	PHYSICAL THERAPY	29,872	9,360	28,924		8,295		24,190
053	ELECTROCARDIOLOGY					621		6,805
055	MEDICAL SUPPLIES CHARGED	14,700		14,233		1,273		36,214
056	DRUGS CHARGED TO PATIENTS	22,580		21,863		2,617		53,995
059	PSYCHIATRIC/PSYCHOLOGICAL	14,361		13,905				7,736
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	19,219	12,279	18,609		8,729	37,113	17,702
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC	29,665		28,723		2,780		19,837
	OTHER REIMBURS COST CNTRS							
[illegible]	HOME HEALTH AGENCY	15,892		15,387				
	SPEC PURPOSE COST CENTERS							
[illegible]	SUBTOTALS	507,635	287,431	479,849	362,667	140,883	202,995	462,754
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	DR. OFFICE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	TOTAL	507,635	287,431	479,849	362,667	140,883	202,995	462,754

		COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	I&R COST POST STEP-DOWN ADJ	TOTAL
			18	25	26	27
		GENERAL SERVICE COST CNTR				
003		NEW CAP REL COSTS-BLDG &				
004		NEW CAP REL COSTS-MVBLE E				
005		EMPLOYEE BENEFITS				
006		ADMINISTRATIVE & GENERAL				
007		MAINTENANCE & REPAIRS				
008		OPERATION OF PLANT				
009		LAUNDRY & LINEN SERVICE				
010		HOUSEKEEPING				
011		DIETARY				
012		CAFETERIA				
014		NURSING ADMINISTRATION				
017		MEDICAL RECORDS & LIBRARY				
018		SOCIAL SERVICE	112,784			
		INPAT ROUTINE SRVC CNTRS				
025		ADULTS & PEDIATRICS	112,784	2,778,323		2,778,323
026		INTENSIVE CARE UNIT		382,536		382,536
033		NURSERY		25,815		25,815
034		SKILLED NURSING FACILITY		1,651,200		1,651,200
035		NURSING FACILITY		3,554,369		3,554,369
		ANCILLARY SRVC COST CNTRS				
037		OPERATING ROOM		1,558,918		1,558,918
039		DELIVERY ROOM & LABOR ROO				
041		RADIOLOGY-DIAGNOSTIC		1,916,790		1,916,790
044		LABORATORY		2,461,004		2,461,004
049		RESPIRATORY THERAPY		336,445		336,445
050		PHYSICAL THERAPY		1,205,688		1,205,688
053		ELECTROCARDIOLOGY		61,163		61,163
055		MEDICAL SUPPLIES CHARGED		1,060,735		1,060,735
056		DRUGS CHARGED TO PATIENTS		1,438,954		1,438,954
059		PSYCHIATRIC/PSYCHOLOGICAL		494,729		494,729
		OUTPAT SERVICE COST CNTRS				
061		EMERGENCY		1,704,933		1,704,933
062		OBSERVATION BEDS (NON-DIS				
063		OTHER OUTPATIENT SERVICE				
063	50	RURAL HEALTH CLINIC		2,506,591		2,506,591
		OTHER REIMBURS COST CNTRS				
		HOME HEALTH AGENCY		554,787		554,787
		SPEC PURPOSE COST CENTERS				
[illegible]		SUBTOTALS	112,784	23,692,980		23,692,980
		NONREIMBURS COST CENTERS				
096		GIFT, FLOWER, COFFEE SHOP				
100		DR. OFFICE				
101		CROSS FOOT ADJUSTMENT				
102		NEGATIVE COST CENTER				
103		TOTAL	112,784	23,692,980		23,692,980

ALLOCATION OF NEW CAPITAL RELATED COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET B I PART III

	COST CENTER DESCRIPTION	DIR ASSGNED NEW CAPITAL REL COSTS	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE E	SUBTOTAL	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS
		0	3	4	4a	5	6	7
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL		57,084	38,365	95,449		95,449	
007	MAINTENANCE & REPAIRS		25,858	17,378	43,236		2,949	46,185
008	OPERATION OF PLANT		16,901	11,359	28,260		2,314	1,353
009	LAUNDRY & LINEN SERVICE		11,678	7,849	19,527		1,249	935
010	HOUSEKEEPING		1,616	1,086	2,702		2,217	129
011	DIETARY		4,246	2,853	7,099		1,637	340
012	CAFETERIA		4,520	3,038	7,558		585	362
014	NURSING ADMINISTRATION		1,169	785	1,954		936	94
017	MEDICAL RECORDS & LIBRARY		10,098	6,787	16,885		2,023	808
018	SOCIAL SERVICE		1,461	982	2,443		506	117
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS		133,295	89,586	222,881		9,284	10,673
026	INTENSIVE CARE UNIT		12,171	8,180	20,351		1,471	974
033	NURSERY		3,095	2,080	5,175		29	248
034	SKILLED NURSING FACILITY		78,093	52,485	130,578		4,701	6,252
035	NURSING FACILITY							
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM		59,275	39,838	99,113		6,128	4,746
039	DELIVERY ROOM & LABOR ROO							
041	RADIOLOGY-DIAGNOSTIC		41,799	28,093	69,892		7,927	3,346
044	LABORATORY		20,708	13,918	34,626		10,919	1,658
049	RESPIRATORY THERAPY		15,376	10,334	25,710		1,253	1,231
050	PHYSICAL THERAPY		32,952	22,147	55,099		5,056	2,638
053	ELECTROCARDIOLOGY						254	
055	MEDICAL SUPPLIES CHARGED		16,216	10,898	27,114		4,618	1,298
056	DRUGS CHARGED TO PATIENTS		24,908	16,740	41,648		6,198	1,994
059	PSYCHIATRIC/PSYCHOLOGICAL		15,841	10,647	26,488		2,088	1,268
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY		21,201	14,249	35,450		7,415	1,697
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC		32,724	21,993	54,717		11,306	2,620
	OTHER REIMBURS COST CNTRS							
	HOME HEALTH AGENCY		17,531	11,782	29,313		2,386	1,404
	SPEC PURPOSE COST CENTERS							
	SUBTOTALS		659,816	443,452	1,103,268		95,449	46,185
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	DR. OFFICE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL		659,816	443,452	1,103,268		95,449	46,185

	COST CENTER DESCRIPTION	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY
		8	9	10	11	12	14	17
	GENERAL SERVICE COST CNTR							
003	NEW CAP REL COSTS-BLDG &							
004	NEW CAP REL COSTS-MVBLE E							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENERAL							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	31,927						
009	LAUNDRY & LINEN SERVICE	666	22,377					
010	HOUSEKEEPING	92	606	5,746				
011	DIETARY	242	337	45	9,700			
012	CAFETERIA	258	326	48		9,137		
014	NURSING ADMINISTRATION	67		12		102	3,165	
017	MEDICAL RECORDS & LIBRARY	576		106		392		20,790
018	SOCIAL SERVICE	83		15		101		
	INPAT ROUTINE SRVC CNTRS							
025	ADULTS & PEDIATRICS	7,598	6,730	1,400	2,868	1,171	1,196	1,417
026	INTENSIVE CARE UNIT	694	513	128	333	164	168	193
033	NURSERY	176	846	33				
034	SKILLED NURSING FACILITY	4,452	9,493	821	6,499	749	766	339
035	NURSING FACILITY					3,124		
	ANCILLARY SRVC COST CNTRS							
037	OPERATING ROOM	3,380	1,841	623		446	456	1,491
039	DELIVERY ROOM & LABOR ROO							
041	RADIOLOGY-DIAGNOSTIC	2,383		439		399		5,113
044	LABORATORY	1,181		218		801		3,593
049	RESPIRATORY THERAPY	877		162		111		1,156
050	PHYSICAL THERAPY	1,879	729	346		538		1,088
053	ELECTROCARDIOLOGY					40		306
055	MEDICAL SUPPLIES CHARGED	925		170		83		1,629
056	DRUGS CHARGED TO PATIENTS	1,420		262		170		2,429
059	PSYCHIATRIC/PSYCHOLOGICAL	903		167				348
	OUTPAT SERVICE COST CNTRS							
061	EMERGENCY	1,209	956	223		566	579	796
062	OBSERVATION BEDS (NON-DIS							
063	OTHER OUTPATIENT SERVICE							
063 50	RURAL HEALTH CLINIC	1,866		344		180		892
	OTHER REIMBURS COST CNTRS							
	HOME HEALTH AGENCY	1,000		184				
	SPEC PURPOSE COST CENTERS							
[illegible]	SUBTOTALS	31,927	22,377	5,746	9,700	9,137	3,165	20,790
	NONREIMBURS COST CENTERS							
096	GIFT, FLOWER, COFFEE SHOP							
100	DR. OFFICE							
101	CROSS FOOT ADJUSTMENTS							
102	NEGATIVE COST CENTER							
103	TOTAL	31,927	22,377	5,746	9,700	9,137	3,165	20,790

	COST CENTER DESCRIPTION	SOCIAL SERVICE	SUBTOTAL	POST STEPDOWN ADJUSTMENT	TOTAL
		18	25	26	27
	GENERAL SERVICE COST CNTR				
003	NEW CAP REL COSTS-BLDG &				
004	NEW CAP REL COSTS-MVBLE E				
005	EMPLOYEE BENEFITS				
006	ADMINISTRATIVE & GENERAL				
007	MAINTENANCE & REPAIRS				
008	OPERATION OF PLANT				
009	LAUNDRY & LINEN SERVICE				
010	HOUSEKEEPING				
011	DIETARY				
012	CAFETERIA				
014	NURSING ADMINISTRATION				
017	MEDICAL RECORDS & LIBRARY				
018	SOCIAL SERVICE	3,265			
	INPAT ROUTINE SRVC CNTRS				
025	ADULTS & PEDIATRICS	3,265	268,483		268,483
026	INTENSIVE CARE UNIT		24,989		24,989
033	NURSERY		6,507		6,507
034	SKILLED NURSING FACILITY		164,650		164,650
035	NURSING FACILITY		3,124		3,124
	ANCILLARY SRVC COST CNTRS				
037	OPERATING ROOM		118,224		118,224
039	DELIVERY ROOM & LABOR ROO				
041	RADIOLOGY-DIAGNOSTIC		89,499		89,499
044	LABORATORY		52,996		52,996
049	RESPIRATORY THERAPY		30,500		30,500
050	PHYSICAL THERAPY		67,373		67,373
053	ELECTROCARDIOLOGY		600		600
055	MEDICAL SUPPLIES CHARGED		35,837		35,837
056	DRUGS CHARGED TO PATIENTS		54,121		54,121
059	PSYCHIATRIC/PSYCHOLOGICAL		31,262		31,262
	OUTPAT SERVICE COST CNTRS				
061	EMERGENCY		48,891		48,891
062	OBSERVATION BEDS (NON-DIS				
063	OTHER OUTPATIENT SERVICE				
063 50	RURAL HEALTH CLINIC		71,925		71,925
	OTHER REIMBURS COST CNTRS				
	HOME HEALTH AGENCY		34,287		34,287
	SPEC PURPOSE COST CENTERS				
095	SUBTOTALS	3,265	1,103,268		1,103,268
	NONREIMBURS COST CENTERS				
096	GIFT, FLOWER, COFFEE SHOP				
100	DR. OFFICE				
101	CROSS FOOT ADJUSTMENTS				
102	NEGATIVE COST CENTER				
103	TOTAL	3,265	1,103,268		1,103,268

COST ALLOCATION - STATISTICAL BASIS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET B-1

	COST CENTER DESCRIPTION	NEW CAP REL COSTS-BLDG & (SQUARE FEET)	NEW CAP REL COSTS-MVBLE & (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)
		3	4	5	6a.00	6	7
	GENERAL SERVICE COST						
003	NEW CAP REL COSTS-BLD	72,265					
004	NEW CAP REL COSTS-MVB		72,265				
005	EMPLOYEE BENEFITS			9,412,090			
006	ADMINISTRATIVE & GENE	6,252	6,252	845,102	-2,986,940	17,199,857	
007	MAINTENANCE & REPAIRS	2,832	2,832	209,310		531,386	63,181
008	OPERATION OF PLANT	1,851	1,851			416,955	1,851
009	LAUNDRY & LINEN SERVI	1,279	1,279			225,125	1,279
010	HOUSEKEEPING	177	177	234,760		399,481	177
011	DIETARY	465	465	106,902		294,956	465
012	CAFETERIA	495	495	85,977		105,432	495
014	NURSING ADMINISTRATIO	128	128	127,347		168,766	128
017	MEDICAL RECORDS & LIB	1,106	1,106	247,160		364,485	1,106
018	SOCIAL SERVICE	160	160	67,347		91,209	160
	INPAT ROUTINE SRVC CN						
025	ADULTS & PEDIATRICS	14,599	14,599	1,133,120		1,673,068	14,599
026	INTENSIVE CARE UNIT	1,333	1,333	190,479		265,013	1,333
033	NURSERY	339	339			5,175	339
034	SKILLED NURSING FACIL	8,553	8,553	550,290		847,191	8,553
035	NURSING FACILITY				-3,506,183		
	ANCILLARY SRVC COST C						
037	OPERATING ROOM	6,492	6,492	950,462		1,104,353	6,492
039	DELIVERY ROOM & LABOR						
041	RADIOLOGY-DIAGNOSTIC	4,578	4,578	411,430		1,428,564	4,578
044	LABORATORY	2,268	2,268	730,725		1,967,715	2,268
049	RESPIRATORY THERAPY	1,684	1,684	102,608		225,767	1,684
050	PHYSICAL THERAPY	3,609	3,609	675,103		911,185	3,609
053	ELECTROCARDIOLOGY			37,089		45,786	
055	MEDICAL SUPPLIES CHAR	1,776	1,776	43,393		832,254	1,776
056	DRUGS CHARGED TO PATI	2,728	2,728	213,293		1,116,993	2,728
059	PSYCHIATRIC/PSYCHOLOG	1,735	1,735	180,992		376,259	1,735
	OUTPAT SERVICE COST C						
061	EMERGENCY	2,322	2,322	663,832		1,336,298	2,322
	OBSERVATION BEDS (NON						
	OTHER OUTPATIENT SERV						
50	RURAL HEALTH CLINIC	3,584	3,584	1,339,259		2,036,543	3,584
	OTHER REIMBURS COST C						
071	HOME HEALTH AGENCY	1,920	1,920	266,110		429,898	1,920
	SPEC PURPOSE COST CEN						
095	SUBTOTALS	72,265	72,265	9,412,090	-6,493,123	17,199,857	63,181
	NONREIMBURS COST CENT						
096	GIFT, FLOWER, COFFEE						
100	DR. OFFICE						
101	CROSS FOOT ADJUSTMENT						
102	NEGATIVE COST CENTER						
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	659,816	443,452	2,206,990		2,986,940	623,667
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	9.130506	6.136470	.234485		.173661	9.871116
105	COST TO BE ALLOCATED (WRKSHT B, PART II)						
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)						
107	COST TO BE ALLOCATED (WRKSHT B, PART III					95,449	46,185
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)					.005549	.730995

	COST CENTER DESCRIPTION	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (PAID HOURS)	NURSING ADMINISTRATION (DIRECT NSING HRS)	MEDICAL RECORDS & LIBRARY (GROSS REV)
		8	9	10	11	12	14	17
	GENERAL SERVICE COST							
003	NEW CAP REL COSTS-BLD							
004	NEW CAP REL COSTS-MVB							
005	EMPLOYEE BENEFITS							
006	ADMINISTRATIVE & GENE							
007	MAINTENANCE & REPAIRS							
008	OPERATION OF PLANT	61,330						
009	LAUNDRY & LINEN SERVI	1,279	192,881					
010	HOUSEKEEPING	177	5,222	59,874				
011	DIETARY	465	2,901	465	41,955			
012	CAFETERIA	495	2,813	495		437,386		
014	NURSING ADMINISTRATIO	128		128		4,881	148,221	
017	MEDICAL RECORDS & LIB	1,106		1,106		18,743		48,514,749
018	SOCIAL SERVICE	160		160		4,816		
	INPAT ROUTINE SRVC CN							
025	ADULTS & PEDIATRICS	14,599	58,010	14,599	12,404	56,039	56,039	3,303,095
026	INTENSIVE CARE UNIT	1,333	4,425	1,333	1,441	7,857	7,857	449,365
033	NURSERY	339	7,296	339				
034	SKILLED NURSING FACIL	8,553	81,823	8,553	28,110	35,862	35,862	789,331
035	NURSING FACILITY					149,598		
	ANCILLARY SRVC COST C							
037	OPERATING ROOM	6,492	15,870	6,492		21,364	21,364	3,475,165
039	DELIVERY ROOM & LABOR							
041	RADIOLOGY-DIAGNOSTIC	4,578		4,578		19,080		11,973,206
044	LABORATORY	2,268		2,268		38,330		8,376,149
049	RESPIRATORY THERAPY	1,684		1,684		5,330		2,694,059
050	PHYSICAL THERAPY	3,609	6,281	3,609		25,752		2,536,153
053	ELECTROCARDIOLOGY					1,927		713,498
055	MEDICAL SUPPLIES CHAR	1,776		1,776		3,953		3,796,842
056	DRUGS CHARGED TO PATI	2,728		2,728		8,125		5,660,989
059	PSYCHIATRIC/PSYCHOLOG	1,735		1,735				811,111
	OUTPAT SERVICE COST C							
061	EMERGENCY	2,322	8,240	2,322		27,099	27,099	1,855,951
	OBSERVATION BEDS (NON							
	OTHER OUTPATIENT SERV							
063	50 RURAL HEALTH CLINIC	3,584		3,584		8,630		2,079,835
	OTHER REIMBURS COST C							
071	HOME HEALTH AGENCY	1,920		1,920				
	SPEC PURPOSE COST CEN							
095	SUBTOTALS	61,330	192,881	59,874	41,955	437,386	148,221	48,514,749
	NONREIMBURS COST CENT							
096	GIFT, FLOWER, COFFEE							
100	DR. OFFICE							
101	CROSS FOOT ADJUSTMENT							
102	NEGATIVE COST CENTER							
103	COST TO BE ALLOCATED (WRKSHT B, PART I)	507,635	287,431	479,849	362,667	140,883	202,995	462,754
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	8.277107	1.490199	8.014313	8.644190	.322102	1.369543	.009538
105	COST TO BE ALLOCATED (WRKSHT B, PART II)							
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)							
107	COST TO BE ALLOCATED (WRKSHT B, PART III	31,927	22,377	5,746	9,700	9,137	3,165	20,790
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	.520577	.116015	.095968	.231200	.020890	.021353	.000429

	COST CENTER DESCRIPTION	SOCIAL SERVICE (TIME SPENT)
		18
	GENERAL SERVICE COST	
003	NEW CAP REL COSTS-BLD	
004	NEW CAP REL COSTS-MVB	
005	EMPLOYEE BENEFITS	
006	ADMINISTRATIVE & GENE	
007	MAINTENANCE & REPAIRS	
008	OPERATION OF PLANT	
009	LAUNDRY & LINEN SERVI	
010	HOUSEKEEPING	
011	DIETARY	
012	CAFETERIA	
014	NURSING ADMINISTRATIO	
017	MEDICAL RECORDS & LIB	
018	SOCIAL SERVICE	100
	INPAT ROUTINE SRVC CN	
025	ADULTS & PEDIATRICS	100
026	INTENSIVE CARE UNIT	
033	NURSERY	
034	SKILLED NURSING FACIL	
035	NURSING FACILITY	
	ANCILLARY SRVC COST C	
037	OPERATING ROOM	
039	DELIVERY ROOM & LABOR	
041	RADIOLOGY-DIAGNOSTIC	
044	LABORATORY	
049	RESPIRATORY THERAPY	
050	PHYSICAL THERAPY	
053	ELECTROCARDIOLOGY	
055	MEDICAL SUPPLIES CHAR	
056	DRUGS CHARGED TO PATI	
059	PSYCHIATRIC/PSYCHOLOG	
	OUTPAT SERVICE COST C	
061	EMERGENCY	
[illegible]	OBSERVATION BEDS (NON	
	OTHER OUTPATIENT SERV	
50	RURAL HEALTH CLINIC	
	OTHER REIMBURS COST C	
071	HOME HEALTH AGENCY	
	SPEC PURPOSE COST CEN	
095	SUBTOTALS	100
	NONREIMBURS COST CENT	
096	GIFT, FLOWER, COFFEE	
100	DR. OFFICE	
101	CROSS FOOT ADJUSTMENT	
102	NEGATIVE COST CENTER	
103	COST TO BE ALLOCATED (PER WRKSHT B, PART	112,784
104	UNIT COST MULTIPLIER (WRKSHT B, PT I)	1,127.840000
105	COST TO BE ALLOCATED (PER WRKSHT B, PART	
106	UNIT COST MULTIPLIER (WRKSHT B, PT II)	
107	COST TO BE ALLOCATED (PER WRKSHT B, PART	3,265
108	UNIT COST MULTIPLIER (WRKSHT B, PT III)	32.650000

COMPUTATION OF RATIO OF COSTS TO CHARGES

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,778,323		2,778,323		2,778,323
26	INTENSIVE CARE UNIT	382,536		382,536		382,536
33	NURSERY	25,815		25,815		25,815
34	SKILLED NURSING FACILITY	1,651,200		1,651,200		1,651,200
35	NURSING FACILITY	3,554,369		3,554,369		3,554,369
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,558,918		1,558,918		1,558,918
39	DELIVERY ROOM & LABOR ROO					
41	RADIOLOGY-DIAGNOSTIC	1,916,790		1,916,790		1,916,790
44	LABORATORY	2,461,004		2,461,004		2,461,004
49	RESPIRATORY THERAPY	336,445		336,445		336,445
50	PHYSICAL THERAPY	1,205,688		1,205,688		1,205,688
53	ELECTROCARDIOLOGY	61,163		61,163		61,163
55	MEDICAL SUPPLIES CHARGED	1,060,735		1,060,735		1,060,735
56	DRUGS CHARGED TO PATIENTS	1,438,954		1,438,954		1,438,954
59	PSYCHIATRIC/PSYCHOLOGICAL	494,729		494,729		494,729
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,704,933		1,704,933		1,704,933
62	OBSERVATION BEDS (NON-DIS	650,854		650,854		650,854
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	2,506,591		2,506,591		2,506,591
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,789,047		23,789,047		23,789,047
102	LESS OBSERVATION BEDS	650,854		650,854		650,854
103	TOTAL	23,138,193		23,138,193		23,138,193

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/15/2010 | WORKSHEET C | PART I

WKST A LTR	NO.	COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
	25	ADULTS & PEDIATRICS	2,600,757		2,600,757			
	26	INTENSIVE CARE UNIT	449,365		449,365			
	33	NURSERY						
	34	SKILLED NURSING FACILITY	789,331		789,331			
	35	NURSING FACILITY	4,623,627		4,623,627			
		ANCILLARY SRVC COST CNTRS						
	37	OPERATING ROOM	556,395	2,918,770	3,475,165	.448588	.448588	.448588
	39	DELIVERY ROOM & LABOR ROO						
	41	RADIOLOGY-DIAGNOSTIC	1,517,473	10,455,733	11,973,206	.160090	.160090	.160090
	44	LABORATORY	1,822,075	6,554,074	8,376,149	.293811	.293811	.293811
	49	RESPIRATORY THERAPY	513,511	1,093,350	1,606,861	.209380	.209380	.209380
	50	PHYSICAL THERAPY	880,036	1,656,117	2,536,153	.475400	.475400	.475400
	53	ELECTROCARDIOLOGY	230,186	483,312	713,498	.085723	.085723	.085723
	55	MEDICAL SUPPLIES CHARGED	1,921,885	2,962,154	4,884,039	.217184	.217184	.217184
	56	DRUGS CHARGED TO PATIENTS	2,475,316	3,185,673	5,660,989	.254188	.254188	.254188
	59	PSYCHIATRIC/PSYCHOLOGICAL		811,111	811,111	.609940	.609940	.609940
		OUTPAT SERVICE COST CNTRS						
	61	EMERGENCY	173,953	1,681,998	1,855,951	.918630	.918630	.918630
	62	OBSERVATION BEDS (NON-DIS	101,975	600,363	702,338	.926696	.926696	.926696
	63	OTHER OUTPATIENT SERVICE						
	63	50 RURAL HEALTH CLINIC		2,079,835	2,079,835	1.205187	1.205187	1.205187
		OTHER REIMBURS COST CNTRS						
	101	SUBTOTAL	18,655,885	34,482,490	53,138,375			
	102	LESS OBSERVATION BEDS						
	103	TOTAL	18,655,885	34,482,490	53,138,375			

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL **NOT A CMS WORKSHEET ** (07/2009)

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART I

WKST A LINE NO.	COST CENTER DESCRIPTION	WKST B, PT I COL. 27 1	THERAPY ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5
	INPAT ROUTINE SRVC CNTRS					
25	ADULTS & PEDIATRICS	2,778,323		2,778,323		2,778,323
26	INTENSIVE CARE UNIT	382,536		382,536		382,536
33	NURSERY	25,815		25,815		25,815
34	SKILLED NURSING FACILITY	1,651,200		1,651,200		1,651,200
35	NURSING FACILITY	3,554,369		3,554,369		3,554,369
	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	1,558,918		1,558,918		1,558,918
39	DELIVERY ROOM & LABOR ROO					
41	RADIOLOGY-DIAGNOSTIC	1,916,790		1,916,790		1,916,790
44	LABORATORY	2,461,004		2,461,004		2,461,004
49	RESPIRATORY THERAPY	336,445		336,445		336,445
50	PHYSICAL THERAPY	1,205,688		1,205,688		1,205,688
53	ELECTROCARDIOLOGY	61,163		61,163		61,163
55	MEDICAL SUPPLIES CHARGED	1,060,735		1,060,735		1,060,735
56	DRUGS CHARGED TO PATIENTS	1,438,954		1,438,954		1,438,954
59	PSYCHIATRIC/PSYCHOLOGICAL	494,729		494,729		494,729
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	1,704,933		1,704,933		1,704,933
62	OBSERVATION BEDS (NON-DIS	650,854		650,854		650,854
63	OTHER OUTPATIENT SERVICE					
63 50	RURAL HEALTH CLINIC	2,506,591		2,506,591		2,506,591
	OTHER REIMBURS COST CNTRS					
101	SUBTOTAL	23,789,047		23,789,047		23,789,047
102	LESS OBSERVATION BEDS	650,854		650,854		650,854
103	TOTAL	23,138,193		23,138,193		23,138,193

COMPUTATION OF RATIO OF COSTS TO CHARGES
SPECIAL TITLE XIX WORKSHEET

WKST A LINE NO.		COST CENTER DESCRIPTION	INPATIENT CHARGES 6	OUTPATIENT CHARGES 7	TOTAL CHARGES 8	COST OR OTHER RATIO 9	TEFRA INPATIENT RATIO 10	PPS INPATIENT RATIO 11
		INPAT ROUTINE SRVC CNTRS						
25		ADULTS & PEDIATRICS	2,600,757		2,600,757			
26		INTENSIVE CARE UNIT	449,365		449,365			
33		NURSERY						
34		SKILLED NURSING FACILITY	789,331		789,331			
35		NURSING FACILITY	4,623,627		4,623,627			
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	556,395	2,918,770	3,475,165	.448588	.448588	.448588
39		DELIVERY ROOM & LABOR ROO						
41		RADIOLOGY-DIAGNOSTIC	1,517,473	10,455,733	11,973,206	.160090	.160090	.160090
44		LABORATORY	1,822,075	6,554,074	8,376,149	.293811	.293811	.293811
49		RESPIRATORY THERAPY	513,511	1,093,350	1,606,861	.209380	.209380	.209380
50		PHYSICAL THERAPY	880,036	1,656,117	2,536,153	.475400	.475400	.475400
53		ELECTROCARDIOLOGY	230,186	483,312	713,498	.085723	.085723	.085723
55		MEDICAL SUPPLIES CHARGED	1,921,885	2,962,154	4,884,039	.217184	.217184	.217184
56		DRUGS CHARGED TO PATIENTS	2,475,316	3,185,673	5,660,989	.254188	.254188	.254188
59		PSYCHIATRIC/PSYCHOLOGICAL		811,111	811,111	.609940	.609940	.609940
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	173,953	1,681,998	1,855,951	.918630	.918630	.918630
62		OBSERVATION BEDS (NON-DIS	101,975	600,363	702,338	.926696	.926696	.926696
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC		2,079,835	2,079,835	1.205187	1.205187	1.205187
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	18,655,885	34,482,490	53,138,375			
102		LESS OBSERVATION BEDS						
103		TOTAL	18,655,885	34,482,490	53,138,375			

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III, COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,558,918	118,224	1,440,694			1,558,918
39		DELIVERY ROOM & LABOR ROO						
41		RADIOLOGY-DIAGNOSTIC	1,916,790	89,499	1,827,291			1,916,790
44		LABORATORY	2,461,004	52,996	2,408,008			2,461,004
49		RESPIRATORY THERAPY	336,445	30,500	305,945			336,445
50		PHYSICAL THERAPY	1,205,688	67,373	1,138,315			1,205,688
53		ELECTROCARDIOLOGY	61,163	600	60,563			61,163
55		MEDICAL SUPPLIES CHARGED	1,060,735	35,837	1,024,898			1,060,735
56		DRUGS CHARGED TO PATIENTS	1,438,954	54,121	1,384,833			1,438,954
59		PSYCHIATRIC/PSYCHOLOGICAL	494,729	31,262	463,467			494,729
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,704,933	48,891	1,656,042			1,704,933
62		OBSERVATION BEDS (NON-DIS	650,854		650,854			650,854
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	2,506,591	71,925	2,434,666			2,506,591
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	15,396,804	601,228	14,795,576			15,396,804
102		LESS OBSERVATION BEDS	650,854		650,854			650,854
103		TOTAL	14,745,950	601,228	14,144,722			14,745,950

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/2000)

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART II

WKST A LINE NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	3,475,165	.448588	.448588
39		DELIVERY ROOM & LABOR ROO			
41		RADIOLOGY-DIAGNOSTIC	11,973,206	.160090	.160090
44		LABORATORY	8,376,149	.293811	.293811
49		RESPIRATORY THERAPY	1,606,861	.209380	.209380
50		PHYSICAL THERAPY	2,536,153	.475400	.475400
53		ELECTROCARDIOLOGY	713,498	.085723	.085723
55		MEDICAL SUPPLIES CHARGED	4,884,039	.217184	.217184
56		DRUGS CHARGED TO PATIENTS	5,660,989	.254188	.254188
59		PSYCHIATRIC/PSYCHOLOGICAL	811,111	.609940	.609940
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	1,855,951	.918630	.918630
62		OBSERVATION BEDS (NON-DIS	702,338	.926696	.926696
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	2,079,835	1.205187	1.205187
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	44,675,295		
102		LESS OBSERVATION BEDS	702,338		
103		TOTAL	43,972,957		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL **NOT A CMS WORKSHEET ** (09/2000)
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS SPECIAL TITLE XIX WORKSHEET
PROVIDER NO: 14-1311 PERIOD: FROM 7/ 1/2009 TO 6/30/2010
PREPARED 11/15/2010 WORKSHEET C PART II

WKST A NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	CAPITAL COST WKST B PT II & III,COL. 27 2	OPERATING COST NET OF CAPITAL COST 3	CAPITAL REDUCTION 4	OPERATING COST REDUCTION AMOUNT 5	COST NET OF CAP AND OPER COST REDUCTION 6
		ANCILLARY SRVC COST CNTRS						
37		OPERATING ROOM	1,558,918	118,224	1,440,694			1,558,918
39		DELIVERY ROOM & LABOR ROO						
41		RADIOLOGY-DIAGNOSTIC	1,916,790	89,499	1,827,291			1,916,790
44		LABORATORY	2,461,004	52,996	2,408,008			2,461,004
49		RESPIRATORY THERAPY	336,445	30,500	305,945			336,445
50		PHYSICAL THERAPY	1,205,688	67,373	1,138,315			1,205,688
53		ELECTROCARDIOLOGY	61,163	600	60,563			61,163
55		MEDICAL SUPPLIES CHARGED	1,060,735	35,837	1,024,898			1,060,735
56		DRUGS CHARGED TO PATIENTS	1,438,954	54,121	1,384,833			1,438,954
59		PSYCHIATRIC/PSYCHOLOGICAL	494,729	31,262	463,467			494,729
		OUTPAT SERVICE COST CNTRS						
61		EMERGENCY	1,704,933	48,891	1,656,042			1,704,933
62		OBSERVATION BEDS (NON-DIS	650,854		650,854			650,854
63		OTHER OUTPATIENT SERVICE						
63	50	RURAL HEALTH CLINIC	2,506,591	71,925	2,434,666			2,506,591
		OTHER REIMBURS COST CNTRS						
101		SUBTOTAL	15,396,804	601,228	14,795,576			15,396,804
102		LESS OBSERVATION BEDS	650,854		650,854			650,854
103		TOTAL	14,745,950	601,228	14,144,722			14,745,950

WKST A NO.		COST CENTER DESCRIPTION	TOTAL CHARGES	OUTPAT COST TO CHRG RATIO	I/P PT B COST TO CHRG RATIO
			7	8	9
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	3,475,165	.448588	.448588
39		DELIVERY ROOM & LABOR ROO			
41		RADIOLOGY-DIAGNOSTIC	11,973,206	.160090	.160090
44		LABORATORY	8,376,149	.293811	.293811
49		RESPIRATORY THERAPY	1,606,861	.209380	.209380
50		PHYSICAL THERAPY	2,536,153	.475400	.475400
53		ELECTROCARDIOLOGY	713,498	.085723	.085723
55		MEDICAL SUPPLIES CHARGED	4,884,039	.217184	.217184
56		DRUGS CHARGED TO PATIENTS	5,660,989	.254188	.254188
59		PSYCHIATRIC/PSYCHOLOGICAL	811,111	.609940	.609940
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	1,855,951	.918630	.918630
62		OBSERVATION BEDS (NON-DIS	702,338	.926696	.926696
63		OTHER OUTPATIENT SERVICE			
63	50	RURAL HEALTH CLINIC	2,079,835	1.205187	1.205187
		OTHER REIMBURS COST CNTRS			
101		SUBTOTAL	44,675,295		
102		LESS OBSERVATION BEDS	702,338		
103		TOTAL	43,972,957		

COMPUTATION OF TOTAL RPCH INPATIENT ANCILLARY COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART III

WKST A NO.		COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	TOTAL ANCILLARY CHARGES 2	TOTAL INP ANCILLARY CHARGES 3	CHARGE TO CHARGE RATIO 4	TOTAL INPATIENT COST 5
		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM	698,031	1,358,747			
39		DELIVERY ROOM & LABOR ROO	34,842				
41		RADIOLOGY-DIAGNOSTIC	1,027,971	6,242,107			
44		LABORATORY	1,176,749	3,928,993			
49		RESPIRATORY THERAPY	152,276	681,456			
50		PHYSICAL THERAPY	684,205	1,248,287			
53		ELECTROCARDIOLOGY	27,938	451,100			
55		MEDICAL SUPPLIES CHARGED	448,556	2,063,704			
56		DRUGS CHARGED TO PATIENTS	922,017	2,870,099			
59		PSYCHIATRIC/PSYCHOLOGICAL	255,001	731,014			
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY	696,130	874,038			
62		OBSERVATION BEDS (NON-DIS	250,063	260,799			
63		OTHER OUTPATIENT SERVICE					
63	50	RURAL HEALTH CLINIC					
		OTHER REIMBURS COST CNTRS					
101		TOTAL	6,373,779	20,710,344			

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

COMPUTATION OF OUTPATIENT COST PER VISIT - RURAL PRIMARY CARE HOSPITAL

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET C I PART V

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COST WKST B, PT I COL. 27 1	PROVIDER-BASED PHYSICIAN ADJUSTMENT 2	TOTAL COSTS 3	TOTAL ANCILLARY CHARGES 4	TOTAL OUTPATIENT CHARGES 5	RATIO OF OUT-PATIENT CHRGS TO TTL CHARGES 6	TOTAL OUT-PATIENT COSTS 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM	698,031	206,741	904,772	1,358,747			
39	DELIVERY ROOM & LABOR ROO	34,842		34,842				
41	RADIOLOGY-DIAGNOSTIC	1,027,971		1,027,971	6,242,107			
44	LABORATORY	1,176,749		1,176,749	3,928,993			
49	RESPIRATORY THERAPY	152,276		152,276	681,456			
50	PHYSICAL THERAPY	684,205		684,205	1,248,287			
53	ELECTROCARDIOLOGY	27,938	15,503	43,441	451,100			
55	MEDICAL SUPPLIES CHARGED	448,556		448,556	2,063,704			
56	DRUGS CHARGED TO PATIENTS	922,017		922,017	2,870,099			
59	PSYCHIATRIC/PSYCHOLOGICAL	255,001		255,001	731,014			
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY	696,130	435,080	1,131,210	874,038			
62	OBSERVATION BEDS (NON-DIS	250,063		250,063	260,799			
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL	6,373,779	657,324	7,031,103	20,710,344			
102	TOTAL OUTPATIENT VISITS							
103	AGGREGATE COST PER VISIT							
104	TITLE V OUTPATIENT VISITS							
105	TITLE XVIII OUTPAT VISITS							
106	TITLE XIX OUTPAT VISITS							
107	TITLE V OUTPAT COSTS							
108	TITLE XVIII OUTPAT COSTS							
109	TITLE XIX OUTPAT COSTS							

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1311 I

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		1	1.01	1.02	2	3
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.448588		.448588		
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.160090		.160090		
44	LABORATORY	.293811		.293811		
49	RESPIRATORY THERAPY	.209380		.209380		
50	PHYSICAL THERAPY	.475400		.475400		
53	ELECTROCARDIOLOGY	.085723		.085723		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184		.217184		
56	DRUGS CHARGED TO PATIENTS	.254188		.254188		
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940		.609940		
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.918630		.918630		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.926696		.926696		
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1311 I

TITLE XVIII, PART B HOSPITAL

	Cost Center Description	Other Outpatient Diagnostic	All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic
		4	5	6	7	8
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		966,791			
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC		4,332,764			
44	LABORATORY		3,024,941			
49	RESPIRATORY THERAPY		313,532			
50	PHYSICAL THERAPY		704,365			
53	ELECTROCARDIOLOGY		264,235			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		1,296,561			
56	DRUGS CHARGED TO PATIENTS		1,135,019			
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		806,980			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		453,635			
62	OBSERVATION BEDS (NON-DISTINCT PART)		278,585			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL		13,577,408			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES		13,577,408			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1311 I I I

TITLE XVIII, PART B HOSPITAL

		All Other	Hospital I/P Part B Charges	Hospital I/P Part B Costs
	Cost Center Description	9	10	11
(A)	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	433,691		
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	693,632		
44	LABORATORY	888,761		
49	RESPIRATORY THERAPY	65,647		
50	PHYSICAL THERAPY	334,855		
53	ELECTROCARDIOLOGY	22,651		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	281,592		
56	DRUGS CHARGED TO PATIENTS	288,508		
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	492,209		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	416,723		
62	OBSERVATION BEDS (NON-DISTINCT PART)	258,164		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
101	SUBTOTAL	4,176,433		
102	CRNA CHARGES			
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES			
104	NET CHARGES	4,176,433		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

I	PROVIDER NO:	I PERIOD:	I PREPARED 11/15/2010
I	14-1311	I FROM 7/ 1/2009	I WORKSHEET D
I	COMPONENT NO:	I TO 6/30/2010	I PART VI
I	14-1311	I	I

TITLE XVIII, PART B HOSPITAL

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.254188
2	PROGRAM VACCINE CHARGES	373
3	PROGRAM COSTS	95

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(09/1996)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART II

I COMPONENT NO: 14-5552

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

W/S A NO.	COST CENTER DESCRIPTION	OLD CAPITAL RELATED COST 1	NEW CAPITAL RELATED COST 2	TOTAL CHARGES 3	INPAT PROGRAM CHARGES 4	OLD CAPITAL CST/CHRG RATIO 5	COSTS 6
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

PROVIDER NO:	PERIOD:		PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009		WORKSHEET D
COMPONENT NO:	TO 6/30/2010		PART II
14-5552			

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A NO.	COST CENTER DESCRIPTION	NEW CAPITAL CST/CHRG RATIO	COSTS
		7	8
	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM		
39	DELIVERY ROOM & LABOR ROO		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
53	ELECTROCARDIOLOGY		
55	MEDICAL SUPPLIES CHARGED		
56	DRUGS CHARGED TO PATIENTS		
59	PSYCHIATRIC/PSYCHOLOGICAL		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DIS		
63	OTHER OUTPATIENT SERVICE		
63 50	RURAL HEALTH CLINIC		
	OTHER REIMBURS COST CNTRS		
101	TOTAL		

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

PROVIDER NO:	PERIOD:		PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009		WORKSHEET D
COMPONENT NO:	TO 6/30/2010		PART IV
14-5552			

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A NO.	COST CENTER DESCRIPTION	NONPHYSICIAN ANESTHETIST 1	1.01	MED ED NRS SCHOOL COST 2	MED ED ALLIED HEALTH COST 2.01	MED ED ALL OTHER COSTS 2.02	BLOOD CLOT FOR HEMOPHILIACS 2.03
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63 50	RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

WKST A NO.	COST CENTER DESCRIPTION	TOTAL COSTS 3	O/P PASS THRU COSTS 3.01	TOTAL CHARGES 4	RATIO OF COST TO CHARGES 5	O/P RATIO OF CST TO CHARGES 5.01	INPAT PROG CHARGE 6	INPAT PROG PASS THRU COST 7
	ANCILLARY SRVC COST CNTRS							
37	OPERATING ROOM			3,475,165			207	
39	DELIVERY ROOM & LABOR ROO							
41	RADIOLOGY-DIAGNOSTIC			11,973,206			33,448	
44	LABORATORY			8,376,149			147,141	
49	RESPIRATORY THERAPY			1,606,861			78,075	
50	PHYSICAL THERAPY			2,536,153			554,216	
53	ELECTROCARDIOLOGY			713,498			6,432	
55	MEDICAL SUPPLIES CHARGED			4,884,039			374,646	
56	DRUGS CHARGED TO PATIENTS			5,660,989			94,307	
59	PSYCHIATRIC/PSYCHOLOGICAL			811,111				
	OUTPAT SERVICE COST CNTRS							
61	EMERGENCY			1,855,951				
62	OBSERVATION BEDS (NON-DIS			702,338				
63	OTHER OUTPATIENT SERVICE							
63 50	RURAL HEALTH CLINIC							
	OTHER REIMBURS COST CNTRS							
101	TOTAL			42,595,460			1,288,472	

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96(07/2009) CONTD

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART IV

I COMPONENT NO: 14-5552 I

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A NO.	COST CENTER DESCRIPTION	OUTPAT PROG CHARGES 8	OUTPAT PROG D,V COL 5.03 8.01	OUTPAT PROG D,V COL 5.04 8.02	OUTPAT PROG PASS THRU COST 9	COL 8.01 * COL 5 9.01	COL 8.02 * COL 5 9.02
	ANCILLARY SRVC COST CNTRS						
37	OPERATING ROOM						
39	DELIVERY ROOM & LABOR ROO						
41	RADIOLOGY-DIAGNOSTIC						
44	LABORATORY						
49	RESPIRATORY THERAPY						
50	PHYSICAL THERAPY						
53	ELECTROCARDIOLOGY						
55	MEDICAL SUPPLIES CHARGED						
56	DRUGS CHARGED TO PATIENTS						
59	PSYCHIATRIC/PSYCHOLOGICAL						
	OUTPAT SERVICE COST CNTRS						
61	EMERGENCY						
62	OBSERVATION BEDS (NON-DIS						
63	OTHER OUTPATIENT SERVICE						
63	50 RURAL HEALTH CLINIC						
	OTHER REIMBURS COST CNTRS						
101	TOTAL						

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-5552 I

TITLE XVIII, PART B SKILLED NURSING FACILITY

		Cost/Charge Ratio (C, Pt I, col. 9)	Cost/Charge Ratio (C, Pt II, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic
	Cost Center Description	1	1.02	2	3	4
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.448588	.448588			
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.160090	.160090			
44	LABORATORY	.293811	.293811			
49	RESPIRATORY THERAPY	.209380	.209380			
50	PHYSICAL THERAPY	.475400	.475400			
53	ELECTROCARDIOLOGY	.085723	.085723			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184	.217184			
56	DRUGS CHARGED TO PATIENTS	.254188	.254188			
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940	.609940			
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.918630	.918630			
62	OBSERVATION BEDS (NON-DISTINCT PART)	.926696	.926696			
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D PART V I COMPONENT NO: 14-5552 I

TITLE XVIII, PART B SKILLED NURSING FACILITY

			All Other (1)	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy	Other Outpatient Diagnostic	All Other
		Cost Center Description	5	6	7	8	9
(A)		ANCILLARY SRVC COST CNTRS					
37		OPERATING ROOM					
39		DELIVERY ROOM & LABOR ROOM					
41		RADIOLOGY-DIAGNOSTIC					
44		LABORATORY	2,589				761
49		RESPIRATORY THERAPY					
50		PHYSICAL THERAPY					
53		ELECTROCARDIOLOGY					
55		MEDICAL SUPPLIES CHARGED TO PATIENTS					
56		DRUGS CHARGED TO PATIENTS	165				42
59		PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
		OUTPAT SERVICE COST CNTRS					
61		EMERGENCY					
62		OBSERVATION BEDS (NON-DISTINCT PART)					
63		OTHER OUTPATIENT SERVICE COST CENTER					
63	50	RURAL HEALTH CLINIC					
101		SUBTOTAL	2,754				803
102		CRNA CHARGES					
103		LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104		NET CHARGES	2,754				803

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010
I COMPONENT NO: 14-5552 I WORKSHEET D PART V

TITLE XVIII, PART B SKILLED NURSING FACILITY

	Cost Center Description	Hospital I/P Part B Charges 10	Hospital I/P Part B Costs 11
(A)	ANCILLARY SRVC COST CNTRS		
37	OPERATING ROOM		
39	DELIVERY ROOM & LABOR ROOM		
41	RADIOLOGY-DIAGNOSTIC		
44	LABORATORY		
49	RESPIRATORY THERAPY		
50	PHYSICAL THERAPY		
53	ELECTROCARDIOLOGY		
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		
56	DRUGS CHARGED TO PATIENTS		
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES		
	OUTPAT SERVICE COST CNTRS		
61	EMERGENCY		
62	OBSERVATION BEDS (NON-DISTINCT PART)		
63	OTHER OUTPATIENT SERVICE COST CENTER		
63 50	RURAL HEALTH CLINIC		
101	SUBTOTAL		
102	CRNA CHARGES		
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES		
104	NET CHARGES		

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COST

PROVIDER NO:	PERIOD:		PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009		WORKSHEET D
COMPONENT NO:	TO 6/30/2010		PART VI
14-5552			

TITLE XVIII, PART B SKILLED NURSING FACILITY

PART VI - VACCINE COST APPORTIONMENT

		1
1	DRUGS CHARGED TO PATIENTS-RATIO OF COST TO CHARGES	.254188
2	PROGRAM VACCINE CHARGES	165
3	PROGRAM COSTS	42

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1311 I

TITLE XIX - O/P HOSPITAL

		Cost/Charge Ratio (C, Pt I, col. 9)	Outpatient Ambulatory Surgical Ctr	Outpatient Radiology	Other Outpatient Diagnostic	All Other (1)
	Cost Center Description	1	2	3	4	5
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM	.448588				615,496
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC	.160090				2,162,808
44	LABORATORY	.293811				995,424
49	RESPIRATORY THERAPY	.209380				157,694
50	PHYSICAL THERAPY	.475400				357,190
53	ELECTROCARDIOLOGY	.085723				65,463
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184				547,324
56	DRUGS CHARGED TO PATIENTS	.254188				650,181
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940				
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY	.918630				560,511
62	OBSERVATION BEDS (NON-DISTINCT PART)	.926696				
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC	1.205187				
101	SUBTOTAL					6,112,091
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					6,112,091

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D I PART V

I COMPONENT NO: 14-1311 I

TITLE XIX - O/P HOSPITAL

	Cost Center Description	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE	Outpatient Ambulatory Surgical Ctr	Outpatient Radialogy
		5.01	5.02	5.03	6	7
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM					
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC					
44	LABORATORY					
49	RESPIRATORY THERAPY					
50	PHYSICAL THERAPY					
53	ELECTROCARDIOLOGY					
55	MEDICAL SUPPLIES CHARGED TO PATIENTS					
56	DRUGS CHARGED TO PATIENTS					
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY					
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63 50	RURAL HEALTH CLINIC					
101	SUBTOTAL					
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-PROGRAM ONLY CHARGES					
104	NET CHARGES					

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES & VACCINE COSTS | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | COMPONENT NO: 14-1311 | PREPARED 11/15/2010 | WORKSHEET D | PART V

TITLE XIX - O/P HOSPITAL

		Other Outpatient Diagnostic	All Other	PPS Services FYB to 12/31	Non-PPS Services	PPS Services 1/1 to FYE
	Cost Center Description	8	9	9.01	9.02	9.03
(A)	ANCILLARY SRVC COST CNTRS					
37	OPERATING ROOM		276,104			
39	DELIVERY ROOM & LABOR ROOM					
41	RADIOLOGY-DIAGNOSTIC		346,244			
44	LABORATORY		292,467			
49	RESPIRATORY THERAPY		33,018			
50	PHYSICAL THERAPY		169,808			
53	ELECTROCARDIOLOGY		5,612			
55	MEDICAL SUPPLIES CHARGED TO PATIENTS		118,870			
56	DRUGS CHARGED TO PATIENTS		165,268			
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES					
	OUTPAT SERVICE COST CNTRS					
61	EMERGENCY		514,902			
62	OBSERVATION BEDS (NON-DISTINCT PART)					
63	OTHER OUTPATIENT SERVICE COST CENTER					
63	50 RURAL HEALTH CLINIC					
101	SUBTOTAL		1,922,293			
102	CRNA CHARGES					
103	LESS PBP CLINIC LAB SVCS-					
	PROGRAM ONLY CHARGES					
104	NET CHARGES		1,922,293			

(A) WORKSHEET A LINE NUMBERS
(1) REPORT NON HOSPITAL AND NON SUBPROVIDER COMPONENTS COST FOR THE PERIOD HERE (SEE INSTRUCTIONS)

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-1311		

TITLE XVIII PART A HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,812
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,812
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,812
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,130
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,778,323
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,778,323
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,303,095
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,303,095
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.841127
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	866.50
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,778,323

TITLE XVIII PART A HOSPITAL OTHER

T II - HOSPITAL AND SUBPROVIDERS ONLY

		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	728.84
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,552,429
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM	
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	1,552,429

		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)					
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	382,536	339	1,128.42	254	286,619
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					

		1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST	1,780,840
49	TOTAL PROGRAM INPATIENT COSTS	3,619,888
	PASS THROUGH COST ADJUSTMENTS	
50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	
52	TOTAL PROGRAM EXCLUDABLE COST	
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS	
	TARGET AMOUNT AND LIMIT COMPUTATION	
54	PROGRAM DISCHARGES	
55	TARGET AMOUNT PER DISCHARGE	
56	TARGET AMOUNT	
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT	
58	BONUS PAYMENT	
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET	
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET	
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.	
58.04	RELIEF PAYMENT	
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT	
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)	
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1	
59.03	PROGRAM DISCHARGES AFTER JULY 1	
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)	
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)	
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)	
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)	
	PROGRAM INPATIENT ROUTINE SWING BED COST	
60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)	
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS	
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS	

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART III
14-1311		

TITLE XVIII PART A HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	893
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	728.84
85	OBSERVATION BED COST	650,854

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

TITLE XVIII PART A SNF PPS

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,615
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,615
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,615
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	2,241
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	1,651,200
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	1,651,200
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	789,331
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	789,331
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	2.091898
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	119.32
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	1,651,200

TITLE XVIII PART A SNF PPS

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	1,651,200
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	249.61
68	PROGRAM ROUTINE SERVICE COST	559,376
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	559,376
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	164,650
72	PER DIEM CAPITAL-RELATED COSTS	24.89
73	PROGRAM CAPITAL-RELATED COSTS	55,778
74	INPATIENT ROUTINE SERVICE COST	503,598
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	503,598
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	559,376
80	PROGRAM INPATIENT ANCILLARY SERVICES	434,391
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	993,767

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

	PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
	14-1311	FROM 7/ 1/2009	WORKSHEET D-1
	COMPONENT NO:	TO 6/30/2010	PART I
	14-1311		

TITLE XIX - I/P HOSPITAL OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	3,812
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	3,812
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	3,812
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	330
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	2,778,323
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	2,778,323
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3,303,095
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3,303,095
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.841127
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	866.50
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	2,778,323

TITLE XIX - I/P HOSPITAL OTHER

T II - HOSPITAL AND SUBPROVIDERS ONLY

1

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM					728.84
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					240,517
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM					
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST					240,517
		TOTAL I/P COST 1	TOTAL I/P DAYS 2	AVERAGE PER DIEM 3	PROGRAM DAYS 4	PROGRAM COST 5
42	NURSERY (TITLE V & XIX ONLY)	25,815				
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS					
43	INTENSIVE CARE UNIT	382,536	339	1,128.42		
44	CORONARY CARE UNIT					
45	BURN INTENSIVE CARE UNIT					
46	SURGICAL INTENSIVE CARE UNIT					
47	OTHER SPECIAL CARE					
						1
48	PROGRAM INPATIENT ANCILLARY SERVICE COST					233,466
49	TOTAL PROGRAM INPATIENT COSTS					473,983

PASS THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES
52	TOTAL PROGRAM EXCLUDABLE COST
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST, AND MEDICAL EDUCATION COSTS

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES
55	TARGET AMOUNT PER DISCHARGE
56	TARGET AMOUNT
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT
58	BONUS PAYMENT
58.01	LESSER OF LINES 53/54 OR 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET
58.02	LESSER OF LINES 53/54 OR 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET
58.03	IF LINES 53/54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02 ENTER THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS (LINE 53) ARE LESS THAN EXPECTED COSTS (LINES 54 x 58.02), OR 1 PERCENT OF THE TARGET AMOUNT (LINE 56) OTHERWISE ENTER ZERO.
58.04	RELIEF PAYMENT
59	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT
59.01	ALLOWABLE INPATIENT COST PER DISCHARGE (LINE 59 / LINE 54) (LTCH ONLY)
59.02	PROGRAM DISCHARGES PRIOR TO JULY 1
59.03	PROGRAM DISCHARGES AFTER JULY 1
59.04	PROGRAM DISCHARGES (SEE INSTRUCTIONS)
59.05	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES PRIOR TO JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.06	REDUCED INPATIENT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1 (SEE INSTRUCTIONS) (LTCH ONLY)
59.07	REDUCED INPATIENT COST PER DISCHARGE (SEE INSTRUCTIONS) (LTCH ONLY)
59.08	REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTRUCTIONS)

PROGRAM INPATIENT ROUTINE SWING BED COST

60	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
61	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (SEE INSTRUCTIONS)
62	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS
63	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD
64	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD
65	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS

TITLE XIX - I/P HOSPITAL OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	
68	PROGRAM ROUTINE SERVICE COST	
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	
72	PER DIEM CAPITAL-RELATED COSTS	
73	PROGRAM CAPITAL-RELATED COSTS	
74	INPATIENT ROUTINE SERVICE COST	
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	893
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	728.84
85	OBSERVATION BED COST	650,854

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-5552		

TITLE XIX - I/P SNF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	6,615
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	6,615
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	6,615
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	789,331
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	789,331
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	119.32
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	

		TITLE XIX - I/P	SNF	OTHER
PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY				1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST			
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM			
68	PROGRAM ROUTINE SERVICE COST			
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM			
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS			
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS			164,650
72	PER DIEM CAPITAL-RELATED COSTS			24.89
73	PROGRAM CAPITAL-RELATED COSTS			
74	INPATIENT ROUTINE SERVICE COST			
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS			
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION			
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION			
78	INPATIENT ROUTINE SERVICE COST LIMITATION			
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS			
80	PROGRAM INPATIENT ANCILLARY SERVICES			
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION			
82	TOTAL PROGRAM INPATIENT OPERATING COSTS			
PART IV - COMPUTATION OF OBSERVATION BED COST				
83	TOTAL OBSERVATION BED DAYS			
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM			
85	OBSERVATION BED COST			

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

COMPUTATION OF INPATIENT OPERATING COST

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-1
COMPONENT NO:	TO 6/30/2010	PART I
14-0000		

TITLE XIX - I/P NF OTHER

PART I - ALL PROVIDER COMPONENTS

		1
	INPATIENT DAYS	
1	INPATIENT DAYS (INCLUDING PRIVATE ROOM AND SWING BED DAYS, EXCLUDING NEWBORN)	25,894
2	INPATIENT DAYS (INCLUDING PRIVATE ROOM, EXCLUDING SWING-BED AND NEWBORN DAYS)	25,894
3	PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	
4	SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	25,894
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
6	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
7	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
8	TOTAL SWING-BED NF TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
9	TOTAL INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	23,766
10	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
11	SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
12	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLES V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
13	SWING-BED NF-TYPE INPATIENT DAYS APPLICABLE TO TITLE V & XIX ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (IF CALENDAR YEAR, ENTER 0 ON THIS LINE)	
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)	
15	TOTAL NURSERY DAYS (TITLE V OR XIX ONLY)	
16	NURSERY DAYS (TITLE V OR XIX ONLY)	
	SWING-BED ADJUSTMENT	
17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	3,554,369
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD	
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD	
26	TOTAL SWING-BED COST (SEE INSTRUCTIONS)	
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	3,554,369
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	
28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	4,623,627
29	PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	
30	SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	4,623,627
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	.768740
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE	
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	178.56
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL	
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL	
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT	
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	3,554,369

TITLE XIX - I/P NF OTHER

PART III - SKILLED NURSING FACILITY, NURSINGFACILITY & ICF/MR ONLY

		1
66	SKILLED NURSING FACILITY/OTHER NURSING FACILITY/ICF/MR ROUTINE SERVICE COST	3,554,369
67	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	137.27
68	PROGRAM ROUTINE SERVICE COST	3,262,359
69	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	
70	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	3,262,359
71	CAPITAL-RELATED COST ALLOCATED TO INPATIENT ROUTINE SERVICE COSTS	3,124
72	PER DIEM CAPITAL-RELATED COSTS	.12
73	PROGRAM CAPITAL-RELATED COSTS	2,852
74	INPATIENT ROUTINE SERVICE COST	3,259,507
75	AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	
76	TOTAL PROGRAM ROUTINE SERVICE COSTS FOR COMPARISON TO THE COST LIMITATION	3,259,507
77	INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	
78	INPATIENT ROUTINE SERVICE COST LIMITATION	
79	REASONABLE INPATIENT ROUTINE SERVICE COSTS	2,852
80	PROGRAM INPATIENT ANCILLARY SERVICES	
81	UTILIZATION REVIEW - PHYSICIAN COMPENSATION	
82	TOTAL PROGRAM INPATIENT OPERATING COSTS	2,852

PART IV - COMPUTATION OF OBSERVATION BED COST

83	TOTAL OBSERVATION BED DAYS	
84	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	
85	OBSERVATION BED COST	

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		COST	ROUTINE COST	COLUMN 1 DIVIDED BY COLUMN 2	TOTAL OBSERVATION BED COST	OBSERVATION BED PASS THROUGH COST
		1	2	3	4	5
86	OLD CAPITAL-RELATED COST					
87	NEW CAPITAL-RELATED COST					
88	NON PHYSICIAN ANESTHETIST					
89	MEDICAL EDUCATION					
89.01	MEDICAL EDUCATION - ALLIED HEA					
89.02	MEDICAL EDUCATION - ALL OTHER					

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 6/30/2010	
14-1311		

TITLE XVIII, PART A HOSPITAL OTHER

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS		1,672,050	
26	INTENSIVE CARE UNIT		328,930	
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.448588	341,581	153,229
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.160090	1,197,326	191,680
44	LABORATORY	.293811	1,409,690	414,182
49	RESPIRATORY THERAPY	.209380	311,098	65,138
50	PHYSICAL THERAPY	.475400	144,485	68,688
53	ELECTROCARDIOLOGY	.085723	195,881	16,792
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184	1,164,553	252,922
56	DRUGS CHARGED TO PATIENTS	.254188	1,682,852	427,761
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.918630	142,365	130,781
62	OBSERVATION BEDS (NON-DISTINCT PART)	.926696	64,387	59,667
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		6,654,218	1,780,840
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		6,654,218	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

I PROVIDER NO: 14-1311 I PERIOD: I FROM 7/ 1/2009 I TO 6/30/2010 I PREPARED 11/15/2010 I WORKSHEET D-4

I COMPONENT NO: 14-5552 I

TITLE XVIII, PART A SKILLED NURSING FACILITY PPS

WKST A NO.	COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
	INPAT ROUTINE SRVC CNTRS			
25	ADULTS & PEDIATRICS			
26	INTENSIVE CARE UNIT			
	ANCILLARY SRVC COST CNTRS			
37	OPERATING ROOM	.448588	207	93
39	DELIVERY ROOM & LABOR ROOM			
41	RADIOLOGY-DIAGNOSTIC	.160090	33,448	5,355
44	LABORATORY	.293811	147,141	43,232
49	RESPIRATORY THERAPY	.209380	78,075	16,347
50	PHYSICAL THERAPY	.475400	554,216	263,474
53	ELECTROCARDIOLOGY	.085723	6,432	551
55	MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184	374,646	81,367
56	DRUGS CHARGED TO PATIENTS	.254188	94,307	23,972
59	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940		
	OUTPAT SERVICE COST CNTRS			
61	EMERGENCY	.918630		
62	OBSERVATION BEDS (NON-DISTINCT PART)	.926696		
63	OTHER OUTPATIENT SERVICE COST CENTER			
63 50	RURAL HEALTH CLINIC			
	OTHER REIMBURS COST CNTRS			
101	TOTAL		1,288,472	434,391
102	LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103	NET CHARGES		1,288,472	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET D-4
COMPONENT NO:	TO 6/30/2010	
14-1311		

TITLE XIX HOSPITAL OTHER

WKST A NO.		COST CENTER DESCRIPTION	RATIO COST TO CHARGES 1	INPATIENT CHARGES 2	INPATIENT COST 3
		INPAT ROUTINE SRVC CNTRS			
25		ADULTS & PEDIATRICS		399,794	
26		INTENSIVE CARE UNIT		38,850	
		ANCILLARY SRVC COST CNTRS			
37		OPERATING ROOM	.448588	98,167	44,037
39		DELIVERY ROOM & LABOR ROOM			
41		RADIOLOGY-DIAGNOSTIC	.160090	124,132	19,872
44		LABORATORY	.293811	114,068	33,514
49		RESPIRATORY THERAPY	.209380	55,097	11,536
50		PHYSICAL THERAPY	.475400	16,834	8,003
53		ELECTROCARDIOLOGY	.085723	3,979	341
55		MEDICAL SUPPLIES CHARGED TO PATIENTS	.217184	208,426	45,267
56		DRUGS CHARGED TO PATIENTS	.254188	223,947	56,925
59		PSYCHIATRIC/PSYCHOLOGICAL SERVICES	.609940		
		OUTPAT SERVICE COST CNTRS			
61		EMERGENCY	.918630	15,208	13,971
62		OBSERVATION BEDS (NON-DISTINCT PART)	.926696		
63		OTHER OUTPATIENT SERVICE COST CENTER			
63	50	RURAL HEALTH CLINIC	1.205187		
		OTHER REIMBURS COST CNTRS			
101		TOTAL		859,858	233,466
102		LESS PBP CLINIC LABORATORY SERVICES - PROGRAM ONLY CHARGES			
103		NET CHARGES		859,858	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 6/30/2010	PART B
14-1311		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		HOSPITAL
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	4,176,528
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	4,176,528
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	4,218,293
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	CAH DEDUCTIBLES	74,544
18.01	CAH ACTUAL BILLED COINSURANCE LINE 17.01 (SEE INSTRUCTIONS)	2,122,339
19	SUBTOTAL (SEE INSTRUCTIONS)	2,021,410
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	2,021,410
24	PRIMARY PAYER PAYMENTS	745
25	SUBTOTAL	2,020,665
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	784,141
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	784,141
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	2,804,806
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	2,804,806
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	2,596,192
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	208,614
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET E
COMPONENT NO:	TO 6/30/2010	PART B
14-5552		

PART B - MEDICAL AND OTHER HEALTH SERVICES

		SNF
1	MEDICAL AND OTHER SERVICES (SEE INSTRUCTIONS)	845
1.01	MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER APRIL 1, 2001 (SEE INSTRUCTIONS).	
1.02	PPS PAYMENTS RECEIVED INCLUDING OUTLIERS.	
1.03	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO.	
1.04	LINE 1.01 TIMES LINE 1.03.	
1.05	LINE 1.02 DIVIDED BY LINE 1.04.	
1.06	TRANSITIONAL CORRIDOR PAYMENT (SEE INSTRUCTIONS)	
1.07	ENTER THE AMOUNT FROM WORKSHEET D, PART IV, (COLS 9, 9.01, 9,02) LINE 101.	
2	INTERNS AND RESIDENTS	
3	ORGAN ACQUISITIONS	
4	COST OF TEACHING PHYSICIANS	
5	TOTAL COST (SEE INSTRUCTIONS)	845
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
6	ANCILLARY SERVICE CHARGES	2,919
7	INTERNS AND RESIDENTS SERVICE CHARGES	
8	ORGAN ACQUISITION CHARGES	
9	CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS.	
10	TOTAL REASONABLE CHARGES	2,919
	CUSTOMARY CHARGES	
11	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
12	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e).	
13	RATIO OF LINE 11 TO LINE 12	
14	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	2,919
15	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	2,074
16	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
17	LESSER OF COST OR CHARGES (FOR CAH SEE INSTRUC)	845
17.01	TOTAL PROSPECTIVE PAYMENT (SUM OF LINES 1.02, 1.06 AND 1.07)	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DEDUCTIBLES AND COINSURANCE (SEE INSTRUCTIONS)	444
18.01	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 17.01 (SEE INSTRUCTIONS)	
19	SUBTOTAL (SEE INSTRUCTIONS)	401
20	SUM OF AMOUNTS FROM WORKSHEET E PARTS C, D & E (SEE INSTR.)	
21	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
22	ESRD DIRECT MEDICAL EDUCATION COSTS	
23	SUBTOTAL	401
24	PRIMARY PAYER PAYMENTS	
25	SUBTOTAL	401
	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	
26	COMPOSITE RATE ESRD	
27	BAD DEBTS (SEE INSTRUCTIONS)	
27.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	
27.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
28	SUBTOTAL	401
29	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION.	
30	OTHER ADJUSTMENTS (SPECIFY)	
30.99	OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)	
31	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS.	
32	SUBTOTAL	401
33	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)	
34	INTERIM PAYMENTS	401
34.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
35	BALANCE DUE PROVIDER/PROGRAM	
36	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2	
	TO BE COMPLETED BY CONTRACTOR	
50	ORIGINAL OUTLIER AMOUNT (SEE INSTRUCTIONS)	
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)	
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY	
53	TIME VALUE OF MONEY (SEE INSTRUCTIONS)	
54	TOTAL (SUM OF LINES 51 AND 53)	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET E-1
COMPONENT NO:	TO 6/30/2010	
14-1311		

TITLE XVIII HOSPITAL

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	AMOUNT 2	PART B MM/DD/YYYY 3	AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			3,115,318		2,602,592
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50			1/21/2010	6,400
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		-6,400
4	TOTAL INTERIM PAYMENTS			3,115,318		2,596,192
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01		117,910		208,614
		SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			3,233,228		2,804,806

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

PROVIDER NO:	14-1311	PERIOD:	PREPARED 11/15/2010
COMPONENT NO:	14-5552	FROM 7/ 1/2009 TO 6/30/2010	WORKSHEET E-1

TITLE XVIII SNF

	DESCRIPTION		INPATIENT-PART A MM/DD/YYYY 1	INPATIENT-PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			664,157		343
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		58
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			664,157		401
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER	.01			
		SETTLEMENT TO PROGRAM	.02			
7	TOTAL MEDICARE PROGRAM LIABILITY			664,157		401

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

---

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010	PART II
14-1311		

PART II - MEDICARE PART A SERVICES - COST REIMBURSEMENT

		HOSPITAL
1	INPATIENT SERVICES	3,619,888
1.01	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT	
2	ORGAN ACQUISITION	
3	COST OF TEACHING PHYSICIANS	
4	SUBTOTAL	3,619,888
5	PRIMARY PAYER PAYMENTS	
6	TOTAL COST. FOR CAH (SEE INSTRUCTIONS)	3,656,087
	COMPUTATION OF LESSER OF COST OR CHARGES	
	REASONABLE CHARGES	
7	ROUTINE SERVICE CHARGES	
8	ANCILLARY SERVICE CHARGES	
9	ORGAN ACQUISITION CHARGES, NET OF REVENUE	
10	TEACHING PHYSICIANS	
11	TOTAL REASONABLE CHARGES	
	CUSTOMARY CHARGES	
12	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIA BLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	
13	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)	
14	RATIO OF LINE 12 TO LINE 13 (NOT TO EXCEED 1.000000)	
15	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)	
16	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	
17	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	
18	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS	
19	COST OF COVERED SERVICES	3,656,087
20	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)	552,992
21	EXCESS REASONABLE COST	
22	SUBTOTAL	3,103,095
23	COINSURANCE	3,220
24	SUBTOTAL	3,099,875
25	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESS IONAL SERVICES (SEE INSTRUCTIONS)	133,353
25.01	ADJUSTED REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)	133,353
25.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES	
26	SUBTOTAL	3,233,228
27	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVID ER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION	
28	OTHER ADJUSTMENTS (SPECIFY)	
29	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS	
30	SUBTOTAL	3,233,228
31	SEQUESTRATION ADJUSTMENT	
32	INTERIM PAYMENTS	3,115,318
32.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)	
33	BALANCE DUE PROVIDER/PROGRAM	117,910
34	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.	

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2009	PREPARED 11/15/2010
COMPONENT NO: 14-5552	TO 6/30/2010	WORKSHEET E-3 PART III

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII SNF

		PPS TITLE V OR TITLE XIX 1	TITLE XVIII SNF PPS 2
	COMPUTATION OF NET COST OF COVERED SERVICE		
1	INPATIENT HOSPITAL/SNF/NF SERVICES		
2	MEDICAL AND OTHER SERVICES		
3	INTERNS AND RESIDENTS (SEE INSTRUCTIONS)		
4	ORGAN ACQUISITION (CERT TRANSPLANT CENTERS ONLY)		
5	COST OF TEACHING PHYSICIANS (SEE INSTRUCTIONS)		
6	SUBTOTAL		
7	INPATIENT PRIMARY PAYER PAYMENTS		
8	OUTPATIENT PRIMARY PAYER PAYMENTS		
9	SUBTOTAL		
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
10	ROUTINE SERVICE CHARGES		
11	ANCILLARY SERVICE CHARGES		
12	INTERNS AND RESIDENTS SERVICE CHARGES		
13	ORGAN ACQUISITION CHARGES, NET OF REVENUE		
14	TEACHING PHYSICIANS		
15	INCENTIVE FROM TARGET AMOUNT COMPUTATION		
16	TOTAL REASONABLE CHARGES		
	CUSTOMARY CHARGES		
17	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
18	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(e)		
19	RATIO OF LINE 17 TO LINE 18		
20	TOTAL CUSTOMARY CHARGES (SEE INSTRUCTIONS)		
21	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
22	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
23	COST OF COVERED SERVICES		
	PROSPECTIVE PAYMENT AMOUNT		
24	OTHER THAN OUTLIER PAYMENTS		786,816
25	OUTLIER PAYMENTS		
26	PROGRAM CAPITAL PAYMENTS		
27	CAPITAL EXCEPTION PAYMENTS (SEE INSTRUCTIONS)		
28	ROUTINE SERVICE OTHER PASS THROUGH COSTS		
29	ANCILLARY SERVICE OTHER PASS THROUGH COSTS		
30	SUBTOTAL		786,816
31	CUSTOMARY CHARGES (TITLE XIX PPS COVERED SERVICES ONLY)		
32	TITLES V OR XIX PPS, LESSER OF LNS 30 OR 31; NON PPS & TITLE XVIII ENTER AMOUNT FROM LINE 30		786,816
33	DEDUCTIBLES (EXCLUDE PROFESSIONAL COMPONENT)		4,710
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
34	EXCESS OF REASONABLE COST		
35	SUBTOTAL		782,106
36	COINSURANCE		117,949
37	SUM OF AMOUNTS FROM WKST. E, PARTS C, D & E, LN 19		
38	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
38.01	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS ENDING BEFORE 10/01/05 (SEE INSTRUCTIONS)		
38.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES		
38.03	ADJUSTED REIMBURSABLE BAD DEBTS FOR PERIODS BEGINNING ON OR AFTER 10/01/05 (SEE INSTRUCTIONS)		
39	UTILIZATION REVIEW		
40	SUBTOTAL (SEE INSTRUCTIONS)		664,157
41	INPATIENT ROUTINE SERVICE COST		
42	MEDICARE INPATIENT ROUTINE CHARGES		
43	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS		
44	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT OF PART A SERVICES		
45	RATIO OF LINE 43 TO 44		
46	TOTAL CUSTOMARY CHARGES		
47	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST		
48	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES		
49	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION		
50	OTHER ADJUSTMENTS (SPECIFY)		
51	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
52	SUBTOTAL		664,157
53	INDIRECT MEDICAL EDUCATION ADJUSTMENT (PPS ONLY)		
54	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS		
55	TOTAL AMOUNT PAYABLE TO THE PROVIDER		664,157
56	SEQUESTRATION ADJUSTMENT (SEE INSTRUCTIONS)		
57	INTERIM PAYMENTS		664,157
57.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
58	BALANCE DUE PROVIDER/PROGRAM		
59	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS)		

CALCULATION OF REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:		PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009		WORKSHEET E-3
COMPONENT NO:	TO 6/30/2010		PART III
14-5552			

PART III - TITLE V OR TITLE XIX SERVICES OR TITLE XVIII SNF PPS ONLY

TITLE XVIII SNF

	PPS TITLE V OR TITLE XIX	TITLE XVIII SNF PPS
	1	2

IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2.

	ASSETS	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT ASSETS				
1	CASH ON HAND AND IN BANKS	1,987,001			
2	TEMPORARY INVESTMENTS				
3	NOTES RECEIVABLE				
4	ACCOUNTS RECEIVABLE	7,479,901			
5	OTHER RECEIVABLES	487,905			
6	LESS: ALLOWANCE FOR UNCOLLECTIBLE NOTES & ACCOUNTS RECEIVABLE	-3,905,125			
7	INVENTORY	348,892			
8	PREPAID EXPENSES	190,738			
9	OTHER CURRENT ASSETS				
10	DUE FROM OTHER FUNDS				
11	TOTAL CURRENT ASSETS	6,589,312			
	FIXED ASSETS				
12	LAND				
12.01					
13	LAND IMPROVEMENTS				
13.01	LESS ACCUMULATED DEPRECIATION				
14	BUILDINGS	26,473,334			
14.01	LESS ACCUMULATED DEPRECIATION	-15,001,878			
15	LEASEHOLD IMPROVEMENTS				
15.01	LESS ACCUMULATED DEPRECIATION				
16	FIXED EQUIPMENT				
16.01	LESS ACCUMULATED DEPRECIATION				
17	AUTOMOBILES AND TRUCKS				
17.01	LESS ACCUMULATED DEPRECIATION				
18	MAJOR MOVABLE EQUIPMENT				
18.01	LESS ACCUMULATED DEPRECIATION				
19	MINOR EQUIPMENT DEPRECIABLE				
19.01	LESS ACCUMULATED DEPRECIATION				
20	MINOR EQUIPMENT-NONDEPRECIABLE				
21	TOTAL FIXED ASSETS	11,471,456			
	OTHER ASSETS				
22	INVESTMENTS	7,525			
23	DEPOSITS ON LEASES				
24	DUE FROM OWNERS/OFFICERS	478,228			
25	OTHER ASSETS	399,109			
26	TOTAL OTHER ASSETS	884,862			
27	TOTAL ASSETS	18,945,630			

	LIABILITIES AND FUND BALANCE	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND
		1	2	3	4
	CURRENT LIABILITIES				
28	ACCOUNTS PAYABLE	1,296,761			
29	SALARIES, WAGES & FEES PAYABLE	370,883			
30	PAYROLL TAXES PAYABLE				
31	NOTES AND LOANS PAYABLE (SHORT TERM)	359,137			
32	DEFERRED INCOME				
33	ACCELERATED PAYMENTS				
34	DUE TO OTHER FUNDS				
35	OTHER CURRENT LIABILITIES	570,027			
36	TOTAL CURRENT LIABILITIES	2,596,808			
	LONG TERM LIABILITIES				
37	MORTGAGE PAYABLE				
38	NOTES PAYABLE	4,368,351			
39	UNSECURED LOANS				
40.01	LOANS PRIOR TO 7/1/66				
40.02	ON OR AFTER 7/1/66				
41	OTHER LONG TERM LIABILITIES				
42	TOTAL LONG-TERM LIABILITIES	4,368,351			
43	TOTAL LIABILITIES	6,965,159			
	CAPITAL ACCOUNTS				
44	GENERAL FUND BALANCE	11,980,471			
45	SPECIFIC PURPOSE FUND				
46	DONOR CREATED- ENDOWMENT FUND BALANCE- RESTRICTED				
47	DONOR CREATED- ENDOWMENT FUND BALANCE- UNRESTRICT				
48	GOVERNING BODY CREATED- ENDOWMENT FUND BALANCE				
49	PLANT FUND BALANCE-INVESTED IN PLANT				
50	PLANT FUND BALANCE- RESERVE FOR PLANT IMPROVEMENT, REPLACEMENT AND EXPANSION				
51	TOTAL FUND BALANCES	11,980,471			
52	TOTAL LIABILITIES AND FUND BALANCES	18,945,630			

STATEMENT OF CHANGES IN FUND BALANCES

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET G-1
	TO 6/30/2010	

		GENERAL FUND 1	2	SPECIFIC PURPOSE FUND 3	4
1	FUND BALANCE AT BEGINNING OF PERIOD		11,836,245		
2	NET INCOME (LOSS)		307,386		
3	TOTAL		12,143,631		
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL		12,143,631		
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM	163,160			
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS		163,160		
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET		11,980,471		

		ENDOWMENT FUND 5	6	PLANT FUND 7	8
1	FUND BALANCE AT BEGINNING OF PERIOD				
2	NET INCOME (LOSS)				
3	TOTAL				
	ADDITIONS (CREDIT ADJUSTMENTS) (SPECIFY)				
4	ADDITIONS (CREDIT ADJUSTM				
5					
6					
7					
8					
9					
10	TOTAL ADDITIONS				
11	SUBTOTAL				
	DEDUCTIONS (DEBIT ADJUSTMENTS) (SPECIFY)				
12	DEDUCTIONS (DEBIT ADJUSTM				
13					
14					
15					
16					
17					
18	TOTAL DEDUCTIONS				
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET				

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/15/2010 | WORKSHEET G-2 | PARTS I & II

PART I - PATIENT REVENUES

		REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3
		GENERAL INPATIENT ROUTINE CARE SERVICES			
1	00	HOSPITAL	3,303,095		3,303,095
4	00	SWING BED - SNF			
5	00	SWING BED - NF			
6	00	SKILLED NURSING FACILITY	789,331		789,331
7	00	NURSING FACILITY	4,623,627		4,623,627
9	00	TOTAL GENERAL INPATIENT ROUTINE CARE	8,716,053		8,716,053
		INTENSIVE CARE TYPE INPATIENT HOSPITAL SVCS			
10	00	INTENSIVE CARE UNIT	449,365		449,365
15	00	TOTAL INTENSIVE CARE TYPE INPAT HOSP	449,365		449,365
16	00	TOTAL INPATIENT ROUTINE CARE SERVICE	9,165,418		9,165,418
17	00	ANCILLARY SERVICES	10,090,830	31,802,292	41,893,122
18	00	OUTPATIENT SERVICES			
18	50	RURAL HEALTH CLINIC		2,079,835	2,079,835
19	00	HOME HEALTH AGENCY		690,655	690,655
24	00	PRO FEES	524,971	3,802,372	4,327,343
25	00	TOTAL PATIENT REVENUES	19,781,219	38,375,154	58,156,373

PART II-OPERATING EXPENSES

26	00	OPERATING EXPENSES		25,412,600
		ADD (SPECIFY)		
27	00	ADD (SPECIFY)		
28	00			
29	00			
30	00			
31	00			
32	00			
33	00	TOTAL ADDITIONS		
		DEDUCT (SPECIFY)		
34	00	DEDUCT (SPECIFY)	3,536,826	
35	00			
36	00			
37	00			
38	00			
39	00	TOTAL DEDUCTIONS		3,536,826
40	00	TOTAL OPERATING EXPENSES		21,875,774

STATEMENT OF REVENUES AND EXPENSES | PROVIDER NO: 14-1311 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010 | PREPARED 11/15/2010 WORKSHEET G-3

	DESCRIPTION	
1	TOTAL PATIENT REVENUES	58,156,373
2	LESS: ALLOWANCES AND DISCOUNTS ON	31,204,557
3	NET PATIENT REVENUES	26,951,816
4	LESS: TOTAL OPERATING EXPENSES	21,875,774
5	NET INCOME FROM SERVICE TO PATIENT	5,076,042
	OTHER INCOME	
6	CONTRIBUTIONS, DONATIONS, BEQUES	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEG	
9	REVENUE FROM TELEVISION AND RADI	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN S	
14	REVENUE FROM MEALS SOLD TO EMPLO	
15	REVENUE FROM RENTAL OF LIVING QU	
16	REVENUE FROM SALE OF MEDICAL & S TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OT	
18	REVENUE FROM SALE OF MEDICAL REC	
19	TUITION (FEES, SALE OF TEXTBOOKS	
20	REVENUE FROM GIFTS,FLOWER, COFFE	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER OPERATING REVENUE	215,627
24.10		
25	TOTAL OTHER INCOME	215,627
26	TOTAL	5,291,669
	OTHER EXPENSES	
27	WAYFAIR	4,623,627
28	NON-OPERATING REVENUE	360,656
29		
30	TOTAL OTHER EXPENSES	4,984,283
31	NET INCOME (OR LOSS) FOR THE PERIO	307,386

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2007)
ANALYSIS OF PROVIDER-BASED
HOME HEALTH AGENCY COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET H
HHA NO:	TO 6/30/2010	
14-7612		

HHA 1

		SALARIES	EMPLOYEE BENEFITS	TRANSPORTATION	CONTRACTED/ PURCHASED SVCS	OTHER COSTS	TOTAL
		1	2	3	4	5	6
	GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMIN & GENERAL	66,110				71,941	138,051
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	200,000					200,000
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE						
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHER						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)	266,110				71,941	338,051

		RECLASSIFI-CATIONS	RECLASSIFIED TRIAL BALANCE	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION
		7	8	9	10
	GENERAL SERVICE COST CENTERS				
1	CAP-REL COST-BLDG & FIX				
2	CAP-REL COST-MOV EQUIP				
3	PLANT OPER & MAINT				
4	TRANSPORTATION				
5	ADMIN & GENERAL	135	138,186		138,186
	HHA REIMBURSABLE SERVICES				
6	SKILLED NURSING CARE		200,000		200,000
7	PHYSICAL THERAPY				
8	OCCUPATIONAL THERAPY				
9	SPEECH PATHOLOGY				
10	MEDICAL SOCIAL SERVICES				
11	HOME HEALTH AIDE				
12	SUPPLIES				
13	DRUGS				
13.20	COST ADMINISTERING DRUGS				
14	DME				
	HHA NONREIMBURSABLE SERVICES				
15	HOME DIALYSIS AIDE SVCS				
16	RESPIRATORY THERAPY				
17	PRIVATE DUTY NURSING				
18	CLINIC				
19	HEALTH PROM ACTIVITIES				
20	DAY CARE PROGRAM				
21	HOME DEL MEALS PROGRAM				
22	HOMEMAKER SERVICE				
23	ALL OTHER				
23.50	TELEMEDICINE				
24	TOTAL (SUM OF LINES 1-23)	135	338,186		338,186

HHA 1

		NET EXPENSES FOR COST ALLOCATION	CAP-REL COST-BLDG & FIX	CAP-REL COST-MOV EQUIP	PLANT OPER & MAINT	TRANSPORTATIO N	SUBTOTAL	ADMINISTRATIV E & GENERAL
		0	1	2	3	4	4A	5
	GENERAL SERVICE COST CENTERS							
1	CAP-REL COST-BLDG & FIX							
2	CAP-REL COST-MOV EQUIP							
3	PLANT OPER & MAINT							
4	TRANSPORTATION							
5	ADMINISTRATIVE & GENERAL	138,186					138,186	138,186
	HHA REIMBURSABLE SERVICES							
6	SKILLED NURSING CARE	200,000					200,000	138,186
7	PHYSICAL THERAPY							
8	OCCUPATIONAL THERAPY							
9	SPEECH PATHOLOGY							
10	MEDICAL SOCIAL SERVICES							
11	HOME HEALTH AIDE							
12	SUPPLIES							
13	DRUGS							
13.20	COST ADMINISTERING DRUGS							
14	DME							
	HHA NONREIMBURSABLE SERVICES							
15	HOME DIALYSIS AIDE SVCS							
16	RESPIRATORY THERAPY							
17	PRIVATE DUTY NURSING							
18	CLINIC							
19	HEALTH PROM ACTIVITIES							
20	DAY CARE PROGRAM							
21	HOME DEL MEALS PROGRAM							
22	HOMEMAKER SERVICE							
23	ALL OTHERS							
23.50	TELEMEDICINE							
24	TOTAL (SUM OF LINES 1-23)	338,186					338,186	

		TOTAL
		6
	GENERAL SERVICE COST CENTERS	
	CAP-REL COST-BLDG & FIX	
2	CAP-REL COST-MOV EQUIP	
3	PLANT OPER & MAINT	
4	TRANSPORTATION	
5	ADMINISTRATIVE & GENERAL	
	HHA REIMBURSABLE SERVICES	
6	SKILLED NURSING CARE	338,186
7	PHYSICAL THERAPY	
8	OCCUPATIONAL THERAPY	
9	SPEECH PATHOLOGY	
10	MEDICAL SOCIAL SERVICES	
11	HOME HEALTH AIDE	
12	SUPPLIES	
13	DRUGS	
13.20	COST ADMINISTERING DRUGS	
14	DME	
	HHA NONREIMBURSABLE SERVICES	
15	HOME DIALYSIS AIDE SVCS	
16	RESPIRATORY THERAPY	
17	PRIVATE DUTY NURSING	
18	CLINIC	
19	HEALTH PROM ACTIVITIES	
20	DAY CARE PROGRAM	
21	HOME DEL MEALS PROGRAM	
22	HOMEMAKER SERVICE	
23	ALL OTHERS	
23.50	TELEMEDICINE	
24	TOTAL (SUM OF LINES 1-23)	338,186

HHA 1

		CAP-REL COST-BLDG & FIX (SQUARE FEET) 1	CAP-REL COST-MOV EQUIP (DOLLAR VALUE) 2	PLANT OPER & MAINT (SQUARE FEET) 3	TRANSPORTATION (MILEAGE) 4	RECONCILIATION ( ) 5A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 5
	GENERAL SERVICE COST CENTERS						
1	CAP-REL COST-BLDG & FIX						
2	CAP-REL COST-MOV EQUIP						
3	PLANT OPER & MAINT						
4	TRANSPORTATION						
5	ADMINISTRATIVE & GENERAL					-138,186	200,000
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE						200,000
7	PHYSICAL THERAPY						
8	OCCUPATIONAL THERAPY						
9	SPEECH PATHOLOGY						
10	MEDICAL SOCIAL SERVICES						
11	HOME HEALTH AIDE						
12	SUPPLIES						
13	DRUGS						
13.20	COST ADMINISTERING DRUGS						
14	DME						
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SVCS						
16	RESPIRATORY THERAPY						
17	PRIVATE DUTY NURSING						
18	CLINIC						
19	HEALTH PROM ACTIVITIES						
20	DAY CARE PROGRAM						
21	HOME DEL MEALS PROGRAM						
22	HOMEMAKER SERVICE						
23	ALL OTHERS						
23.50	TELEMEDICINE						
24	TOTAL (SUM OF LINES 1-23)					-138,186	200,000
25	COST TO BE ALLOCATED						138,186
26	UNIT COST MULIPLIER						.690930

HHA 1

	HHA COST CENTER	HHA TRIAL BALANCE (1) 0	NEW CAP REL COSTS-BLDG & 3	NEW CAP REL COSTS-MVBLE 4	EMPLOYEE BENEFITS 5	SUBTOTAL 5A	ADMINISTRATIVE & GENERAL 6
1	ADMIN & GENERAL		17,531	11,782	62,399	91,712	15,927
2	SKILLED NURSING CARE	338,186				338,186	58,730
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)	338,186	17,531	11,782	62,399	429,898	74,657
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

	HHA COST CENTER	MAINTENANCE & REPAIRS 7	OPERATION OF PLANT 8	LAUNDRY & LINEN SERVICE 9	HOUSEKEEPING 10	DIETARY 11	CAFETERIA 12
1	ADMIN & GENERAL	18,953	15,892		15,387		
2	SKILLED NURSING CARE						
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)	18,953	15,892		15,387		
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

HHA 1

	HHA COST CENTER	NURSING ADMINISTRATION 14	MEDICAL RECORDS & LIBRAR 17	SOCIAL SERVICE 18	SUBTOTAL 25	POST STEP DOWN ADJUST 26	SUBTOTAL 27
1	ADMIN & GENERAL				157,871		157,871
2	SKILLED NURSING CARE				396,916		396,916
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19) (2)				554,787		554,787
21	UNIT COST MULIPLIER						

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

	HHA COST CENTER	ALLOCATED HHA A & G 28	TOTAL HHA COSTS 29
1	ADMIN & GENERAL		
2	SKILLED NURSING CARE	157,871	554,787
3	PHYSICAL THERAPY		
4	OCCUPATIONAL THERAPY		
5	SPEECH PATHOLOGY		
6	MEDICAL SOCIAL SERVICES		
7	HOME HEALTH AIDE		
8	SUPPLIES		
9	DRUGS		
9.20	COST ADMINISTERING DRUGS		
10	DME		
11	HOME DIALYSIS AIDE SVCS		
12	RESPIRATORY THERAPY		
13	PRIVATE DUTY NURSING		
14	CLINIC		
15	HEALTH PROM ACTIVITIES		
16	DAY CARE PROGRAM		
17	HOME DEL MEALS PROGRAM		
18	HOMEMAKER SERVICE		
19	ALL OTHER		
19.50	TELEMEDICINE		
20	TOTAL (SUM OF 1-19) (2)	157,871	554,787
21	UNIT COST MULIPLIER	0.397744	

(1) COLUMN 0, LINE 20 MUST AGREE WITH WKST. A, COLUMN 7, LINE 71.
(2) COLUMNS 0 THROUGH 27, LINE 20 MUST AGREE WITH THE CORRESPONDING COLUMNS OF WKST. B, PART I, LINE 71.

Health Financial Systems MCRIF32
ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

FOR FAIRFIELD MEMORIAL HOSPITAL | PROVIDER NO: 14-1311 | HHA NO: 14-7612 | PERIOD: FROM 7/ 1/2009 TO 6/30/2010

IN LIEU OF FORM CMS-2552-96 (05/2007) | PREPARED 11/15/2010 | WORKSHEET H-5 PART II

HHA 1

	HHA COST CENTER	NEW CAP REL COSTS-BLDG & (SQUARE FEET) 3	NEW CAP REL COSTS-MVBLE (SQUARE FEET) 4	EMPLOYEE BENEFITS (GROSS SALARIES) 5	RECONCILIATION 6A	ADMINISTRATIVE & GENERAL (ACCUM. COST) 6	MAINTENANCE & REPAIRS (SQUARE FEET) 7
1	ADMIN & GENERAL	1,920	1,920	266,110		91,712	1,920
2	SKILLED NURSING CARE					338,186	
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19)	1,920	1,920	266,110		429,898	1,920
21	COST TO BE ALLOCATED	17,531	11,782	62,399		74,657	18,953
22	UNIT COST MULIPLIER	9.130729	6.136458	0.234486		0.173662	9.871354

	HHA COST CENTER	OPERATION OF PLANT (SQUARE FEET) 8	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY) 9	HOUSEKEEPING (SQUARE FEET) 10	DIETARY (MEALS SERVED) 11	CAFETERIA (PAID HOURS) 12	NURSING ADMINISTRATION (DIRECT SING HRS) 14
1	ADMIN & GENERAL	1,920		1,920			
2	SKILLED NURSING CARE						
3	PHYSICAL THERAPY						
4	OCCUPATIONAL THERAPY						
5	SPEECH PATHOLOGY						
6	MEDICAL SOCIAL SERVICES						
7	HOME HEALTH AIDE						
8	SUPPLIES						
9	DRUGS						
9.20	COST ADMINISTERING DRUGS						
10	DME						
11	HOME DIALYSIS AIDE SVCS						
12	RESPIRATORY THERAPY						
13	PRIVATE DUTY NURSING						
14	CLINIC						
15	HEALTH PROM ACTIVITIES						
16	DAY CARE PROGRAM						
17	HOME DEL MEALS PROGRAM						
18	HOMEMAKER SERVICE						
19	ALL OTHER						
19.50	TELEMEDICINE						
20	TOTAL (SUM OF 1-19)	1,920		1,920			
21	COST TO BE ALLOCATED	15,892		15,387			
22	UNIT COST MULIPLIER	8.277083		8.014063			

HHA 1

	HHA COST CENTER	MEDICAL RECORDS & LIBRARY (GROSS REV) 17	SOCIAL SERVICE (TIME SPENT) 18
1	ADMIN & GENERAL		
2	SKILLED NURSING CARE		
3	PHYSICAL THERAPY		
4	OCCUPATIONAL THERAPY		
5	SPEECH PATHOLOGY		
6	MEDICAL SOCIAL SERVICES		
7	HOME HEALTH AIDE		
8	SUPPLIES		
9	DRUGS		
9.20	COST ADMINISTERING DRUGS		
10	DME		
11	HOME DIALYSIS AIDE SVCS		
12	RESPIRATORY THERAPY		
13	PRIVATE DUTY NURSING		
14	CLINIC		
15	HEALTH PROM ACTIVITIES		
16	DAY CARE PROGRAM		
17	HOME DEL MEALS PROGRAM		
18	HOMEMAKER SERVICE		
19	ALL OTHER		
19.50	TELEMEDICINE		
20	TOTAL (SUM OF 1-19)		
21	COST TO BE ALLOCATED		
22	UNIT COST MULIPLIER		

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2008)
APPORTIONMENT OF PATIENT SERVICE COSTS

I PROVIDER NO:	I PERIOD:	I PREPARED	11/15/2010
I 14-1311	I FROM 7/ 1/2009	I WORKSHEET	H-6
I HHA NO:	I TO 6/30/2010	I PARTS I II & III	
I 14-7612	I	I HHA 1	

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

	COST PER VISIT COMPUTATION PATIENT SERVICES	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL VISITS	AVERAGE COST PER VISIT	PROGRAM VISITS PART A
			1	2	3	4	5	6
1	SKILLED NURSING	2	554,787		554,787	3,362	165.02	1,109
2	PHYSICAL THERAPY	3				1,036		473
3	OCCUPATIONAL THERAPY	4				331		163
4	SPEECH PATHOLOGY	5				99		39
5	MEDICAL SOCIAL SERVICES	6						
6	HOME HEALTH AIDE SERVICE	7				35		2
7	TOTAL		554,787		554,787	4,863		1,786

		-----PROGRAM VISITS----- PART B		----------COST OF SERVICES-------- PART B		
		NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	TOTAL PROGRAM COST
		7	8	9	10	11	12
1	SKILLED NURSING	1,379		183,007	227,563		410,570
2	PHYSICAL THERAPY	441					
3	OCCUPATIONAL THERAPY	100					
4	SPEECH PATHOLOGY	32					
5	MEDICAL SOCIAL SERVICES						
6	HOME HEALTH AIDE SERVICES						
7	TOTAL	1,952		183,007	227,563		410,570

	LIMITATION COST COMPUTATION PATIENT SERVICES					PROGRAM COST LIMITS	PROGRAM VISITS PART A
		1	2	3	4	5	6
8	SKILLED NURSING	9914					
9	PHYSICAL THERAPY	9914					
10	OCCUPATIONAL THERAPY	9914					
11	SPEECH PATHOLOGY	9914					
12	MEDICAL SOCIAL SERVICES	9914					
13	HOME HEALTH AIDE SERVICE	9914					
14	TOTAL						

		-----PROGRAM VISITS----- PART B		----------COST OF SERVICES-------- PART B		
		NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	PART A	NOT SUBJECT TO DEDUCT & COINSUR	SUBJECT TO DEDUCT & COINSUR	TOTAL PROGRAM COST
		7	8	9	10	11	12
8	SKILLED NURSING						
9	PHYSICAL THERAPY						
10	OCCUPATIONAL THERAPY						
11	SPEECH PATHOLOGY						
12	MEDICAL SOCIAL SERVICES						
13	HOME HEALTH AIDE SERVICE						
14	TOTAL						

Health Financial Systems MCRIF32 FOR FAIRFIELD MEMORIAL HOSPITAL IN LIEU OF FORM CMS-2552-96 (05/2008)

APPORTIONMENT OF PATIENT SERVICE COSTS

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2009	PREPARED 11/15/2010	
HHA NO: 14-7612	TO 6/30/2010	WORKSHEET H-6	
		PARTS I II & III	
		HHA 1	

[ ] TITLE V [X] TITLE XVIII [ ] TITLE XIX

PART I - APPORTIONMENT OF HHA COST CENTERS:
COMPUTATION OF THE LESSER OF AGGREGATE MEDICARE COST OR THE AGGREGATE OF THE MEDICARE LIMITATION

	SUPPLIES AND EQUIPMENT COST COMPUTATION / OTHER PATIENT SERVICES	FROM WKST H-5 PART I COL. 29, LINE:	FACILITY COSTS (FROM WKST H-5 PART I)	SHARED ANCILLARY COSTS (FROM PART II)	TOTAL HHA COSTS	TOTAL CHARGES	RATIO	PROGRAM COVERED CHARGES PART A
			1	2	3	4	5	6
15	COST OF MEDICAL SUPPLIES	8.00				22,000		6,930
16	COST OF DRUGS	9.00						
16.20	COST OF DRUGS	9.20						

		PROGRAM COVERED CHARGES PART B NOT SUBJECT TO DEDUCT & COINSUR	PROGRAM COVERED CHARGES PART B SUBJECT TO DEDUCT & COINSUR	COST OF SERVICES PART A	COST OF SERVICES PART B NOT SUBJECT TO DEDUCT & COINSUR	COST OF SERVICES PART B SUBJECT TO DEDUCT & COINSUR
		7	8	9	10	11
15	COST OF MEDICAL SUPPLIES	14,940				
16	COST OF DRUGS					
16.20	COST OF DRUGS					

	PER BENEFICIARY COST LIMITATION:	MSA NUMBER	AMOUNT
		1	2
162	PROGRAM UNDUP CENSUS FROM WRKST S-4	9914	
17	PER BENE COST LIMITATION (FRM FI)	9914	
18	PER BENE COST LIMITATION (LN 17*18)		

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST C PT I, COL 9	COST TO CHARGE RATIO	TOTAL HHA CHARGES	HHA SHARED ANCILLARY COSTS	TRANSFER TO PART I AS INDICATED
			1	2	3	4
1	PHYSICAL THERAPY	50	.475400			COL 2, LN 2
2	OCCUPATIONAL THERAPY	51				COL 2, LN 3
3	SPEECH PATHOLOGY	52				COL 2, LN 4
4	MEDICAL SUPPLIES CHARGED TO PATIENT	55	.217184			COL 2, LN 15
5	DRUGS CHARGED TO PATIENTS	56	.254188			COL 2, LN 16

PART III - OUTPATIENT THERAPY REDUCTION COMPUATION

		FROM PART I, COL 5	COST PER VISIT	PART B SERVICES SUBJECT TO DEDUCTIBLES AND COINSURANCE: PROGRAM VISITS PRIOR 1/1/1998	PROGRAM VISITS 1/1/1998 TO 12/31/1998	PROGRAM COSTS PRIOR 1/1/1998	PROGRAM COSTS 1/1/1998 TO 12/31/1998	PROG VISITS ON OR AFTER 1/1/1999
		1	2	2.01	3	3.01	4	5
1	PHYSICAL THERAPY	2						
2	OCCUPATIONAL THERAPY	3						
3	SPEECH PATHOLOGY	4						
4	TOTAL (SUM OF LINES 1-3)							

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

PROVIDER NO:	PERIOD:		
14-1311	FROM 7/ 1/2009	PREPARED	11/15/2010
HHA NO:	TO 6/30/2010	WORKSHEET	H-7
14-7612		PARTS	I & II

TITLE XVIII HHA 1

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

		PART A	PART B NOT SUBJECT TO DED & COINS	PART B SUBJECT TO DED & COINS
		1	2	3
1	REASONABLE COST OF SERVICES			
2	TOTAL CHARGES	216,937	267,317	
	CUSTOMARY CHARGES			
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			
4	AMOUNT THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(B)			
5	RATIO OF LINE 3 TO 4 (NOT TO EXCEED 1.000000)			
6	TOTAL CUSTOMARY CHARGES	216,937	267,317	
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST	216,937	267,317	
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES			
9	PRIMARY PAYOR AMOUNTS			

PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

		PART A SERVICES 1	PART B SERVICES 2
10	TOTAL REASONABLE COST		
10.01	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITHOUT OUTLIERS	228,078	275,803
10.02	TOTAL PPS REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	10,409	8,122
10.03	TOTAL PPS REIMBURSEMENT-LUPA EPISODES	2,554	2,346
10.04	TOTAL PPS REIMBURSEMENT-PEP EPISODES	1,975	2,621
10.05	TOTAL PPS REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.06	TOTAL PPS REIMBURSEMENT-SCIC EPISODES		
10.07	TOTAL PPS OUTLIER REIMBURSEMENT-FULL EPISODES WITH OUTLIERS	5,756	3,730
10.08	TOTAL PPS OUTLIER REIMBURSEMENT-PEP EPISODES		
10.09	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC WITHIN A PEP EPISODE		
10.10	TOTAL PPS OUTLIER REIMBURSEMENT-SCIC EPISODES		
10.11	TOTAL OTHER PAYMENTS		
10.12	DME PAYMENTS		
10.13	OXYGEN PAYMENTS		
10.14	PROSTHETIC AND ORTHOTIC PAYMENTS		
11	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (EXCLUDE COINSURANCE)		
12	SUBTOTAL	248,772	292,622
13	EXCESS REASONABLE COST		
14	SUBTOTAL	248,772	292,622
15	COINSURANCE BILLED TO PROGRAM PATIENTS		
16	NET COST	248,772	292,622
17	REIMBURSABLE BAD DEBTS		
17.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
18	TOTAL COSTS - CURRENT COST REPORTING PERIOD	248,772	292,622
19	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS		
20	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM AGENCIES' TERMINATION OR DECREASE IN MEDICARE UTILIZATION		
21	OTHER ADJUSTMENTS (SPECIFY)		
22	SUBTOTAL	248,772	292,622
23	SEQUESTRATION ADJUSTMENT		
24	SUBTOTAL	248,772	292,622
25	INTERIM PAYMENTS	248,772	292,622
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE PROVIDER/PROGRAM		
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II SECTION 115.2		

ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET H-8
HHA NO:	TO 6/30/2010	
14-7612		

TITLE XVIII HHA 1

	DESCRIPTION		PART A MM/DD/YYYY 1	PART A AMOUNT 2	PART B MM/DD/YYYY 3	PART B AMOUNT 4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			248,772		292,622
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE		NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	ADJUSTMENTS TO PROVIDER	.01				
	ADJUSTMENTS TO PROVIDER	.02				
	ADJUSTMENTS TO PROVIDER	.03				
	ADJUSTMENTS TO PROVIDER	.04				
	ADJUSTMENTS TO PROVIDER	.05				
	ADJUSTMENTS TO PROGRAM	.50				
	ADJUSTMENTS TO PROGRAM	.51				
	ADJUSTMENTS TO PROGRAM	.52				
	ADJUSTMENTS TO PROGRAM	.53				
	ADJUSTMENTS TO PROGRAM	.54				
	SUBTOTAL	.99		NONE		NONE
4	TOTAL INTERIM PAYMENTS			248,772		292,622
	TO BE COMPLETED BY INTERMEDIARY					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)					
	TENTATIVE TO PROVIDER	.01				
	TENTATIVE TO PROVIDER	.02				
	TENTATIVE TO PROVIDER	.03				
	TENTATIVE TO PROGRAM	.50				
	TENTATIVE TO PROGRAM	.51				
	TENTATIVE TO PROGRAM	.52				
	SUBTOTAL	.99		NONE		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02				
7	TOTAL MEDICARE PROGRAM LIABILITY			248,772		292,622

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

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(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/
FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-8500		

RHC 1

		COMPENSATION 1	OTHER COSTS 2	TOTAL 3	RECLASSIFICATION 4
	FACILITY HEALTH CARE STAFF COSTS				
1	PHYSICIAN	739,461		739,461	
2	PHYSICIAN ASSISTANT	215,958		215,958	
3	NURSE PRACTITIONER				
4	VISITING NURSE				
5	OTHER NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	LABORATORY TECHNICIAN				
9	OTHER FACILITY HEALTH CARE STAFF COSTS				
10	SUBTOTAL (SUM OF LINES 1-9)	955,419		955,419	
	COSTS UNDER AGREEMENT				
11	PHYSICIAN SERVICES UNDER AGREEMENT				
12	PHYSICIAN SUPERVISION UNDER AGREEMENT				
13	OTHER COSTS UNDER AGREEMENT				
14	SUBTOTAL (SUM OF LINES 11-13)				
	OTHER HEALTH CARE COSTS				
15	MEDICAL SUPPLIES				
16	TRANSPORTATION (HEALTH CARE STAFF)				
17	DEPRECIATION-MEDICAL EQUIPMENT				
18	PROFESSIONAL LIABILITY INSURANCE				
19	OTHER HEALTH CARE COSTS				
20	ALLOWABLE GME COSTS				
21	SUBTOTAL (SUM OF LINES 15-20)				
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	955,419		955,419	
	COSTS OTHER THAN RHC/FQHC SERVICES				
23	PHARMACY				
24	DENTAL				
25	OPTOMETRY				
26	ALL OTHER NONREIMBURSABLE COSTS				
27	NONALLOWABLE GME COSTS				
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)				
	FACILITY OVERHEAD				
29	FACILITY COSTS				
30	ADMINISTRATIVE COSTS	383,840	334,208	718,048	-5,672
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	383,840	334,208	718,048	-5,672
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,339,259	334,208	1,673,467	-5,672

ANALYSIS OF PROVIDER-BASED RURAL HEALTH CLINIC/ FEDERALLY QUALIFIED HEALTH CENTER COSTS

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET M-1
COMPONENT NO:	TO 6/30/2010	
14-8500		

RHC 1

		RECLASSIFIED TRIAL BALANCE 5	ADJUSTMENTS 6	NET EXPENSES FOR ALLOCATION 7
	FACILITY HEALTH CARE STAFF COSTS			
1	PHYSICIAN	739,461		739,461
2	PHYSICIAN ASSISTANT	215,958		215,958
3	NURSE PRACTITIONER			
4	VISITING NURSE			
5	OTHER NURSE			
6	CLINICAL PSYCHOLOGIST			
7	CLINICAL SOCIAL WORKER			
8	LABORATORY TECHNICIAN			
9	OTHER FACILITY HEALTH CARE STAFF COSTS			
10	SUBTOTAL (SUM OF LINES 1-9)	955,419		955,419
	COSTS UNDER AGREEMENT			
11	PHYSICIAN SERVICES UNDER AGREEMENT			
12	PHYSICIAN SUPERVISION UNDER AGREEMENT			
13	OTHER COSTS UNDER AGREEMENT			
14	SUBTOTAL (SUM OF LINES 11-13)			
	OTHER HEALTH CARE COSTS			
15	MEDICAL SUPPLIES			
16	TRANSPORTATION (HEALTH CARE STAFF)			
17	DEPRECIATION-MEDICAL EQUIPMENT			
18	PROFESSIONAL LIABILITY INSURANCE			
19	OTHER HEALTH CARE COSTS			
20	ALLOWABLE GME COSTS			
21	SUBTOTAL (SUM OF LINES 15-20)			
22	TOTAL COST OF HEALTH CARE SERVICES (SUM OF LINES 10, 14, AND 21)	955,419		955,419
	COSTS OTHER THAN RHC/FQHC SERVICES			
23	PHARMACY			
24	DENTAL			
25	OPTOMETRY			
26	ALL OTHER NONREIMBURSABLE COSTS			
27	NONALLOWABLE GME COSTS			
28	TOTAL NONREIMBURSABLE COSTS (SUM OF LINES 23-27)			
	FACILITY OVERHEAD			
29	FACILITY COSTS			
30	ADMINISTRATIVE COSTS	712,376		712,376
31	TOTAL FACILITY OVERHEAD (SUM OF LINES 29 AND 30)	712,376		712,376
32	TOTAL FACILITY COSTS (SUM OF LINES 22, 28 AND 31)	1,667,795		1,667,795

ALLOCATION OF OVERHEAD
TO RHC/FQHC SERVICES

PROVIDER NO: 14-1311	PERIOD: FROM 7/ 1/2009 TO 6/30/2010	PREPARED 11/15/2010
COMPONENT NO: 14-8500		WORKSHEET M-2

RHC 1

VISITS AND PRODUCTIVITY

		NUMBER OF FTE PERSONNEL 1	TOTAL VISITS 2	PRODUCTIVITY STANDARD(1) 3	MINIMUM VISITS 4
	POSITIONS				
1	PHYSICIANS	1.03	9,619	4,200	4,326
2	PHYSICIAN ASSISTANTS			2,100	
3	NURSE PRACTITIONERS	.50	7,431	2,100	1,050
4	SUBTOTAL (SUM OF LINES 1-3)	1.53	17,050		5,376
5	VISITING NURSE				
6	CLINICAL PSYCHOLOGIST				
7	CLINICAL SOCIAL WORKER				
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	1.53	17,050		
9	PHYSICIAN SERVICES UNDER AGREEMENTS				

	DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES	
10	TOTAL COSTS OF HEALTH CARE SERVICES (FROM WORKSHEET M-1, COLUMN 7, LINE 22)	955,419
11	TOTAL NONREIMBURSABLE COSTS (FROM WORKSHEET M-1, COLUMN 7, LINE 28)	
12	COST OF ALL SERVICES (EXCLUDING OVERHEAD) (SUM OF LINES 10 AND 11)	955,419
13	RATIO OF RHC/FQHC SERVICES (LINE 10 DIVIDED BY LINE 12)	1.000000
14	TOTAL FACILITY OVERHEAD (FROM WORKSHEET M-1, COLUMN 7, LINE 31)	712,376
15	PARENT PROVIDER OVERHEAD ALLOCATED TO FACILITY (SEE INSTRUCTIONS)	838,796
16	TOTAL OVERHEAD (SUM OF LINES 14 AND 15)	1,551,172
17	ALLOWABLE GME OVERHEAD (SEE INSTRUCTIONS)	
18	SUBTRACT LINE 17 FROM LINE 16	1,551,172
19	OVERHEAD APPLICABLE TO RHC/FQHC SERVICES (LINE 13 X LINE 18)	1,551,172
20	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (SUM OF LINES 10 AND 19)	2,506,591

		GREATER OF COL. 2 OR COL. 4 5
	POSITIONS	
1	PHYSICIANS	
2	PHYSICIAN ASSISTANTS	
3	NURSE PRACTITIONERS	
4	SUBTOTAL (SUM OF LINES 1-3)	17,050
5	VISITING NURSE	
6	CLINICAL PSYCHOLOGIST	
7	CLINICAL SOCIAL WORKER	
8	TOTAL FTEs AND VISITS (SUM OF LINES 4-7)	17,050
9	PHYSICIAN SERVICES UNDER AGREEMENTS	

(1) THE PRODUCTIVITY STANDARD FOR PHYSICIANS IS 4,200 AND 2,100 FOR ALL OTHERS. IF AN EXCEPTION TO THE STANDARD HAS BEEN GRANTED (WORKSHEET S-8, LINE 13 EQUALS "Y"), COLUMN 3, LINES 1 THRU 3 OF THIS WORKSHEET SHOULD BE BLANK. THIS APPLIES TO RHC ONLY.

CALCULATION OF REIMBURSEMENT SETTLEMENT
FOR RHC/FQHC SERVICES

I	PROVIDER NO:	I PERIOD:	I	PREPARED 11/15/2010
I	14-1311	I FROM 7/ 1/2009	I	WORKSHEET M-3
I	COMPONENT NO:	I TO 6/30/2010	I	
I	14-8500	I	I	

TITLE XVIII RHC 1

	DETERMINATION OF RATE FOR RHC/FQHC SERVICES	
1	TOTAL ALLOWABLE COST OF RHC/FQHC SERVICES (FROM WORKSHEET M-2, LINE 20)	2,506,591
2	COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 15)	
3	TOTAL ALLOWABLE COST EXCLUDING VACCINE (LINE 1 MINUS LINE 2)	2,506,591
4	TOTAL VISITS (FROM WORKSHEET M-2, COLUMN 5, LINE 8)	17,050
5	PHYSICIANS VISITS UNDER AGREEMENT (FROM WORKSHEET M-2, COLUMN 5, LINE 9)	
6	TOTAL ADJUSTED VISITS (LINE 4 PLUS LINE 5)	17,050
7	ADJUSTED COST PER VISIT (LINE 3 DIVIDED BY LINE 6)	147.01

		CALCULATION OF LIMIT (1)	
		PRIOR TO JANUARY 1 1	ON OR AFTER JANUARY 1 2
8	PER VISIT PAYMENT LIMIT (FROM CMS PUB. 27, SEC. 505 OR YOUR INTERMEDIARY)	999.00	999.00
9	RATE FOR PROGRAM COVERED VISITS (SEE INSTRUCTIONS)	147.01	147.01
	CALCULATION OF SETTLEMENT		
10	PROGRAM COVERED VISITS EXCLUDING MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		5,456
11	PROGRAM COST EXCLUDING COSTS FOR MENTAL HEALTH SERVICES (LINE 9 X LINE 10)		802,087
12	PROGRAM COVERED VISITS FOR MENTAL HEALTH SERVICES (FROM INTERMEDIARY RECORDS)		
13	PROGRAM COVERED COSTS FROM MENTAL HEALTH SERVICES (LINE 9 X LINE 12)		
14	LIMIT ADJUSTMENT FOR MENTAL HEALTH SERVICES (LINE 13 X 62.5%)		
15	GRADUATE MEDICAL EDUCATION PASS THROUGH COST (SEE INSTRUCTIONS)		
16	TOTAL PROGRAM COST (SUM OF LINES 11, 14, AND 15, COLUMNS 1, 2 AND 3)*		802,087
16.01	PRIMARY PAYER AMOUNT		
17	LESS: BENEFICIARY DEDUCTIBLE (FROM INTERMEDIARY RECORDS)		55,979
18	NET PROGRAM COST EXCLUDING VACCINES (LINE 16 MINUS SUM OF LINES 16.01 AND 17)		746,108
19	REIMBURSABLE COST OF RHC/FQHC SERVICES, EXCLUDING VACCINE (80% OF LINE 18)		596,886
20	PROGRAM COST OF VACCINES AND THEIR ADMINISTRATION (FROM WORKSHEET M-4, LINE 16)		
21	TOTAL REIMBURSABLE PROGRAM COST (LINE 19 PLUS LINE 20)		596,886
22	REIMBURSABLE BAD DEBTS (SEE INSTRUCTIONS)		
22.01	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)		
23	OTHER ADJUSTMENTS (SPECIFY)		
24	NET REIMBURSABLE AMOUNT (LINES 21 PLUS 22 PLUS OR MINUS LINE 23)		596,886
25	INTERIM PAYMENTS		707,181
25.01	TENTATIVE SETTLEMENT (FOR FISCAL INTERMEDIARY USE ONLY)		
26	BALANCE DUE COMPONENT/PROGRAM (LINE 24 MINUS LINES 25 AND 25.01)		-110,295
27	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB. 15-II, CHAPTER I, SECTION 115.2		

(1) LINES 8 THROUGH 14: FISCAL YEAR PROVIDERS USE COLUMNS 1 & 2, CALENDER YEAR PROVIDERS USE COLUMN 2 ONLY.

* FOR LINE 15, USE COLUMN 2 ONLY FOR GRADUATE MEDICAL EDUCATION PASS THROUGH COST.

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES
[X] RHC [ ] FQHC

PROVIDER NO:	PERIOD:	PREPARED 11/15/2010
14-1311	FROM 7/ 1/2009	WORKSHEET M-5
COMPONENT NO:	TO 6/30/2010	
14-8500		

RHC 1

	DESCRIPTION		PART B MM/DD/YYYY 1	AMOUNT 2
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			584,981
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY, FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE "NONE" OR ENTER A ZERO.			NONE
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	ADJUSTMENTS TO PROVIDER	.01	1/29/2010	122,200
	ADJUSTMENTS TO PROVIDER	.02		
	ADJUSTMENTS TO PROVIDER	.03		
	ADJUSTMENTS TO PROVIDER	.04		
	ADJUSTMENTS TO PROVIDER	.05		
	ADJUSTMENTS TO PROGRAM	.50		
	ADJUSTMENTS TO PROGRAM	.51		
	ADJUSTMENTS TO PROGRAM	.52		
	ADJUSTMENTS TO PROGRAM	.53		
	ADJUSTMENTS TO PROGRAM	.54		
	SUBTOTAL	.99		122,200
4	TOTAL INTERIM PAYMENTS			707,181
	TO BE COMPLETED BY INTERMEDIARY			
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE "NONE" OR ENTER A ZERO. (1)			
	TENTATIVE TO PROVIDER	.01		
	TENTATIVE TO PROVIDER	.02		
	TENTATIVE TO PROVIDER	.03		
	TENTATIVE TO PROGRAM	.50		
	TENTATIVE TO PROGRAM	.51		
	TENTATIVE TO PROGRAM	.52		
	SUBTOTAL	.99		NONE
6	DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON COST REPORT (1)	SETTLEMENT TO PROVIDER .01 SETTLEMENT TO PROGRAM .02		110,295
7	TOTAL MEDICARE PROGRAM LIABILITY			596,886

NAME OF INTERMEDIARY:
INTERMEDIARY NO:

SIGNATURE OF AUTHORIZED PERSON: _____

DATE: ___/___/___

(1) ON LINES 3, 5 AND 6, WHERE AN AMOUNT IS DUE PROVIDER TO PROGRAM, SHOW THE AMOUNT AND DATE ON WHICH THE PROVIDER AGREES TO THE AMOUNT OF REPAYMENT, EVEN THOUGH TOTAL REPAYMENT IS NOT ACCOMPLISHED UNTIL A LATER DATE.